

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1c Film G230 6-16-58 et

6967

CERTIFICATE OF DEATH

06930

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 7877 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Samuel Middle Edwin Last Atkinson				4. DATE OF DEATH Month June Day 10 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 November 1885	
9. AGE (In years last birthday) yrs. 72		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Apartment Manager				10b. KIND OF BUSINESS OR INDUSTRY Apartment Management			
11. BIRTHPLACE (State or foreign country) New York				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel Edward Atkinson				14. MOTHER'S MAIDEN NAME Julia Erickson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 285-14-3154			
17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ACUTE LYMPHOCYTIC LEUKEMIA DUE TO (c) 6 months INTERVAL BETWEEN ONSET AND DEATH one week							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PSEUDOMONAS SEPTICEMIA							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 24 , 19 58 , to June 10 , 19 58 , that I last saw the deceased alive on June 10 , 19 58 , and that death occurred at 2:00a.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard K. Shaw M.D.				ADDRESS (Street, city or town, state) The Clinical Center The National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Richard K. Shaw, M. D.				DATE SIGNED 6/10/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/12/58		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901				ADDRESS Wash. D.C. 14th St., N.W.		24a. REC'D BY REGISTRAR JUN 11 '58	
24b. REGISTRAR'S SIGNATURE W. H. Search							

MEDICAL CERTIFICATION

2

50

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of deceased [Blank]		Sex [Blank]		Age [Blank]	
Date of death [Blank]		Time of death [Blank]		Place of death [Blank]	
Cause of death [Blank]		Nature of disease [Blank]		Duration of disease [Blank]	
Name of attending physician [Blank]		Name of informant [Blank]		Address of informant [Blank]	
Signature of attending physician [Blank]		Signature of informant [Blank]		Date of certificate [Blank]	

6936
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md</u>				c. LENGTH OF STAY IN TB <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Spa + Hosp -</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary Anna Arnel</u>				4. DATE OF DEATH Month <u>6</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>fe</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/5/86</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Federal Govt. Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>							
13. FATHER'S NAME <u>Benjamin Parker</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wynkoop</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>pt's hosp record -</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute heart failure</u> DUE TO <u>446x</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>anemia</u> DUE TO							
(c) <u>severe nephrosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>advanced cerebral sclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 10, 1958</u> , to <u>June 30, 1958</u> , that I last saw the deceased alive on <u>6/30</u> , 19 <u>58</u> , and that death occurred on <u>10:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Daniel B. Washington MD</u>				ADDRESS (Street, city or town, state) <u>6234 Sa Ave NW Wash DC</u>			
DATE SIGNED <u>6/30/58</u>							
PHYSICIAN'S NAME (Type) <u>Daniel B. Washington MD</u>				ADDRESS <u>6234 Sa Ave NW Wash DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-3-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Macedonia Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick County, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Collins</u>				ADDRESS <u>3871 1st St NW</u>		24a. REC'D BY REGISTRAR <u>W. H. Smith</u>	
DATE <u>JUL 3 '58</u>				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John J. Smith</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF BIRTH <i>Jan 15 1880</i>		PLACE OF BIRTH <i>Worcester, Mass.</i>	
MARRIAGE <i>Married</i>		EDUCATION <i>High School</i>		OCCUPATION <i>Engineer</i>		RELIGION <i>Protestant</i>		MANNER OF DEATH <i>Natural</i>		CAUSE OF DEATH <i>Heart Disease</i>	
DATE OF DEATH <i>Jan 20 1925</i>		PLACE OF DEATH <i>Home</i>		TIME OF DEATH <i>10:30 AM</i>		TEMPERATURE <i>Normal</i>		PULSE <i>Normal</i>		RESPIRATION <i>Normal</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		SIGNATURE OF WITNESS <i>John J. Smith</i>		SIGNATURE OF DECEASED <i>John J. Smith</i>		SIGNATURE OF NEAREST RELATIVE <i>John J. Smith</i>		SIGNATURE OF CLERK <i>John J. Smith</i>		SIGNATURE OF JURY <i>John J. Smith</i>	
DATE OF SIGNATURE <i>Jan 20 1925</i>		DATE OF SIGNATURE <i>Jan 20 1925</i>		DATE OF SIGNATURE <i>Jan 20 1925</i>		DATE OF SIGNATURE <i>Jan 20 1925</i>		DATE OF SIGNATURE <i>Jan 20 1925</i>		DATE OF SIGNATURE <i>Jan 20 1925</i>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 18

6968

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN TB 1 1/2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9101 LOUIS AVENUE		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EMMA MATILDA		4. DATE OF DEATH Month June Day 30 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/27/88
9. AGE (In years lost birthday) 69 yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales check writer		10b. KIND OF BUSINESS OR INDUSTRY Hecht Dept. Store	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Touschner		14. MOTHER'S MAIDEN NAME Mary Saxer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 579-32-9273	
17. INFORMANT Mr. Frank J. Baker, 9101 Louis Ave., Silver Spring, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 hrs few yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 3, 1958 to June 30, 1958 , that I last saw the deceased alive on June 30, 1958 , and that death occurred at 9:45 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Leland S. Madden M.D. 1831 Yarnum St. N.E. ACTUAL SIGNATURE Leland S. Madden Washington 15, D.C. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		22b. DATE THEREOF 7/3/58	
22c. NAME OF CEMETERY OR CREMATORY ST. BASIL CHURCH CEMETERY		22d. LOCATION (City, town, or county) (State) DUSHORE, PENNSYLVANIA	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24a. REC'D BY REGISTRAR DATE JUL 2 '58	
ADDRESS Silver Spring, Md.		24b. REGISTRAR'S SIGNATURE W. E. Humphrey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

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CERTIFICATE OF DEATH

1922

FILE NO.

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

DATE OF BIRTH

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH OF SPOUSE

NAME OF CHILD

DATE OF BIRTH OF CHILD

NAME OF CHILD

DATE OF BIRTH OF CHILD

NAME OF CHILD

DATE OF BIRTH OF CHILD

BOND

6969

CERTIFICATE OF DEATH

Reg. Dist. No.

06931
215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE North Carolina COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 31 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Raleigh 70 x - 3	
3. NAME OF DECEASED (Type or print) First Sallie Middle Massey Last BARBER		4. DATE OF DEATH Month June Day 18 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 Feb. 1892
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Azel Grey MASSEY		14. MOTHER'S MAIDEN NAME Duo Adelpia GRIFFEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Son) Horace M. Barber (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Laennec's Cirrhosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 17 May , 19 58 , to 18 June , 19 58 , that I last saw the deceased alive on 18 June , 19 58 , and that death occurred at 3:50 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE R.G. Muth		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 6-19-58	
PHYSICIAN'S NAME (Type) R.G. MUTH, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-23-58	
22c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery		22d. LOCATION (City, town, or county) (State) Raleigh, N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		24a. REC'D BY REGISTRAR JUN 23 58	
ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24b. REGISTRAR'S SIGNATURE W. L. Search	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

06934

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1970

County of Prince George's State of Maryland

Decedent's Name John A. Jones Date of Birth 10-15-1915

Decedent's Address 1000 North Adams Street City Washington State D.C.

Decedent's Sex Male Race White

Decedent's Date of Death 10-1-1970 Place of Death Home

City Washington

Decedent's Usual Residence 1000 North Adams Street City Washington State D.C.

None

no

Signature of Physician John A. Jones M.D.

Signature of Medical Examiner John A. Jones M.D.

Signature of Coroner John A. Jones M.D.

Signature of Registrar John A. Jones M.D.

Signature of Burial Officer John A. Jones M.D.

Signature of Interment Officer John A. Jones M.D.

Signature of Burial Officer John A. Jones M.D.

Signature of Interment Officer John A. Jones M.D.

Signature of Burial Officer John A. Jones M.D.

6971

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Montgomery.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		d. STREET ADDRESS <u>18512 Hazelwood Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Abby</u> Middle <u>Marie</u> Last <u>BAYLY</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/25/89</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>8</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EMERSON W PRICE</u>		14. MOTHER'S MAIDEN NAME <u>Josephine BURGESSER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Son</u>		Address <u>Charles B Bayly, Jr-50 Vanderbdt Ave. N.Y</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>congestive heart failure</u> DUE TO <u>1 year</u> (c) <u>arteriosclerotic ht. disease + myocarditis</u> DUE TO <u>inf.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>57</u> , to <u>3 June</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3 June</u> , 19 <u>58</u> , and that death occurred at <u>11:50 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John M. Wyman</u>		ADDRESS (Street, city or town, state) <u>7659 Old Georgetown Rd. 6-4-58</u>	
PHYSICIAN'S NAME (Type) <u>JOHN M. WYMAN</u>		DATE SIGNED <u>Bethesda, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/6/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>JUN 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6972

Item 7 Film 6231 7-7-58 et

CERTIFICATE OF DEATH

06936

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5421 Wooten Ave.</u>				d. STREET ADDRESS <u>5421 Wooten Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MILTON</u> Middle <u>HYSCORE</u> Last <u>B EALL</u>				4. DATE OF DEATH Month <u>June</u> Day <u>24</u> , 1958 Year <u>19</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1873</u>	9. AGE (In years lost birthday) yrs. <u>84</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James H. Beall</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Morgan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>211-12-7838</u>		17. INFORMANT Address <u>Roland W. Beall, 5421 Wooten Ave., Chevy Chase, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremic Coma with Respiratory Failure</u> DUE TO <u>Asplenic Anemia / Kidney Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Benign Hypertension</u> DUE TO <u>Asplenic Anemia</u> (c) <u>Asplenic Anemia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 15, 1957</u> to <u>June 24, 1958</u> , that I last saw the deceased alive on <u>June 24, 1958</u> and that death occurred at <u>6:40 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Francis T. Shope</u> M.D. <u>3323-D-14. M.D.</u> ADDRESS (Street, city or town, state) <u>Washington 7 D.C.</u> DATE SIGNED <u>JUN 20 1958</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/27/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Park MD</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chorn Funeral Home</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 20 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

NAME OF DECEASED [Faint handwritten name: William Thomas]		SEX Male		AGE 65	
DATE OF DEATH 1933-08-14		TIME OF DEATH 10:00 AM		PLACE OF DEATH Home	
CAUSE OF DEATH [Faint handwritten text: Heart failure]		MANNER OF DEATH Natural		PLACE OF BURIAL [Faint handwritten text: St. Mary's Cemetery]	
SIGNATURE OF PHYSICIAN [Faint handwritten signature]		SIGNATURE OF CORONER [Faint handwritten signature]		SIGNATURE OF WITNESSES [Faint handwritten signatures]	
COUNTY Baltimore		CITY Baltimore		STATE Maryland	

This certificate is to be filled out by the physician or coroner in charge of the case. It should be filled out as soon as possible after death, and should be filed in the office of the Registrar of the Department of Health. The certificate should be filled out in duplicate, and the original should be filed in the office of the Registrar, and the duplicate should be filed in the office of the physician or coroner. The certificate should be filled out in the following manner:

6937

CERTIFICATE OF DEATH

06937

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY in 1b <u>90 days</u>		d. STREET ADDRESS <u>#11 Hilltop Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> First	<u>Floyd</u> Middle	<u>Beasley</u> Last	4. DATE OF DEATH <u>June 16 1958</u> Month Day Year
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-25-84</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>32</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Marshall Beasley</u>		14. MOTHER'S MAIDEN NAME <u>EVA E. Johnston</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-32-7612</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>one month</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-16-</u> , 19 <u>58</u> , to <u>6-16-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-15-</u> , 19 <u>58</u> , and that death occurred at <u>5:05 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Hare</u>		ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u> DATE SIGNED <u>6/16/58</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/18/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey</u>		24a. REC'D BY REGISTRAR <u>Alfred Smith</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		DATE <u>JUN 17 '58</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased <i>Robert A. Hare, M.D.</i>		Age <i>38</i>	
Sex <i>Male</i>		Date of Birth <i>1898</i>	
Place of Birth <i>Massachusetts</i>		Date of Death <i>1936</i>	
Cause of Death <i>Heart Disease</i>		Place of Death <i>Home</i>	
Occupation <i>Physician</i>		Residence <i>123 Main St., Boston, Mass.</i>	
Signature of Physician <i>Robert A. Hare</i>		Signature of Registrar <i>[Signature]</i>	
Date of Certificate <i>1936</i>		Place of Issuance <i>Boston, Mass.</i>	

6938

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>28 hrs 30 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>6505 Westmoreland Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Baby</u> First Middle Last				4. DATE OF DEATH Month <u>6</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/13/58</u>	
9. AGE (In years last birthday) yrs. <u>28</u>				10. IF UNDER 1 YEAR Months <u>7</u> Days <u>28</u> Hours <u>7</u> Min. <u>7</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Harold Lane Benson</u>				14. MOTHER'S MAIDEN NAME <u>Judith Anne Beckel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>mother's chest</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>28 hrs</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6/12</u> , 19 <u>58</u> , to <u>6/13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/13/58</u> , 19 <u>58</u> , and that death occurred at <u>6 p.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. H. Diamond</u>				ADDRESS (Street, city or town, state) <u>8224-9a Ave</u>		DATE SIGNED <u>6/13/58</u>	
PHYSICIAN'S NAME (Type) <u>H. H. DIAMOND</u>				M.D. <u>Silver Spring Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>6-15-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hospital Takoma Park, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare</u> ADDRESS <u>Takoma Park, Md.</u>				24a. REC'D BY REGISTRAR <u>JUN 20 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Hare</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6939

CERTIFICATE OF DEATH

06939

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b 2½ months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cedar Haven Rest Home				e. STREET ADDRESS 804 DALE DRIVE			
f. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JETTIE Middle KEMPER Last BISHOP				4. DATE OF DEATH Month JUNE Day 2 Year 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/5/73	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME GEORGE A. SEAGLE				14. MOTHER'S MAIDEN NAME ELIZABETH WELSH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Alfred E. Fivaz, 804 Dale Drive, Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic sclerotic heart disease - Malnutrition INTERVAL BETWEEN ONSET AND DEATH 3 days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from October, 1955 , to June 2, 1958 , that I last saw the deceased alive on June 2, 1958 , and that death occurred at 3:40 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 113 Carroll St NW Wash DC				DATE SIGNED 6/2/58			
ACTUAL SIGNATURE James R. Coleman M.D.							
PHYSICIAN'S NAME (Type) JAMES R. COLEMAN							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/4/58		22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE JUN 4 '58	
24b. REGISTRAR'S SIGNATURE Overman							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF BIRTH STATE OF MASSACHUSETTS COUNTY OF SUFFOLK CITY OF BOSTON		PLACE OF DEATH STATE OF MASSACHUSETTS COUNTY OF SUFFOLK CITY OF BOSTON	
NAME OF DECEASED JOHN J. BROWN		NAME OF DECEASED JOHN J. BROWN	
SEX MALE		SEX MALE	
AGE 45 YEARS		AGE 45 YEARS	
DATE OF BIRTH JANUARY 1, 1880		DATE OF BIRTH JANUARY 1, 1880	
DATE OF DEATH DECEMBER 31, 1925		DATE OF DEATH DECEMBER 31, 1925	
TIME OF DEATH 10:00 A.M.		TIME OF DEATH 10:00 A.M.	
CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE	
PLACE OF DEATH HOME		PLACE OF DEATH HOME	
SIGNATURE OF DECEASED (None)		SIGNATURE OF DECEASED (None)	
SIGNATURE OF WITNESS (None)		SIGNATURE OF WITNESS (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF CLERK (None)		SIGNATURE OF CLERK (None)	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF BIRTHS AND DEATHS, STATE DEPARTMENT OF HEALTH, BOSTON, MASSACHUSETTS.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6973 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06940

Item 3, Film G-231 7/7/58.cac

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Springfield</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Springfield</u> <u>Washington 16, D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5613 Parkston Road</u>		d. STREET ADDRESS <u>5613 Parkston Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Wendell</u> Middle <u>Phillipps</u> Last <u>BLAKE</u>		4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 18 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Navy Capt. U.S. Govt</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New Hampshire</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Eugene L. Blake</u>		14. MOTHER'S MAIDEN NAME <u>Jessie Adams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>578-50-1014</u>	
17. INFORMANT <u>Betty J. Blake</u>		Address <u>Blake-Same Item #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/30/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington</u> <u>Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda</u>		24a. REC'D BY REGISTRAR <u>Alf Leach</u>	
24b. REGISTRAR'S SIGNATURE <u>Alf Leach</u>		DATE <u>JUN 27 1958</u>	

FOR STATE HEALTH DEPT.

M

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MEDICAL CERTIFICATION

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Birth: _____

5. Place of Birth: _____

6. Usual Residence: _____

7. Date of Death: _____

8. Time of Death: _____

9. Place of Death: _____

10. Cause of Death: _____

11. Manner of Death: _____

12. Signature of Medical Examiner: _____

13. Signature of Coroner: _____

14. Signature of Registrar: _____

15. Signature of Physician: _____

16. Signature of Nurse: _____

17. Signature of Family: _____

18. Signature of Other: _____

19. Signature of Other: _____

20. Signature of Other: _____

21. Signature of Other: _____

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99. Signature of Other: _____

100. Signature of Other: _____

6974

CERTIFICATE OF DEATH

06941

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 802 THAYER AVE.		d. STREET ADDRESS 1802 THAYER AVE	
3. NAME OF DECEASED (Type or print) FRANCES CLARK Boehm		4. DATE OF DEATH JUNE 6 1958	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 13, 1906
9. AGE (In years lost birthday) 52 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) HYATTSTVILLE MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HERBERT Allen OSBOURN		14. MOTHER'S MAIDEN NAME EMMA IRENE BOSWELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-34-8114	
17. INFORMANT R. A. OSBOURN		Address 8204 CEDAR ST SSM	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Breast - with 491X DUE TO Metastases (c)			INTERVAL BETWEEN ONSET AND DEATH 3 days 6 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September, 1950 to 6-6 , 19 58 , that I last saw the deceased alive on 6-4 , 19 58 , and that death occurred at 5:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Michael J. McInerney M.D.		ADDRESS (Street, city or town, state) 1150 - Conn Avenue DATE SIGNED 6-6-58	
PHYSICIAN'S NAME (Type) MICHAEL J. MCINERNEY		Washington D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JUNE 9, 1958	22c. NAME OF CEMETERY OR CREMATORY MT. OLIVE	22d. LOCATION (City, town, or county) (State) WASH. D.C.
23. FUNERAL DIRECTOR'S SIGNATURE W. W. TALTA VULL ADDRESS 3603 14th ST NW		24a. REC'D BY REGISTRAR JUN 9 '58	24b. REGISTRAR'S SIGNATURE Quinn Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6975

CERTIFICATE OF DEATH

06942

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>CONNECTICUT</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. LENGTH OF STAY IN 1b <u>18 mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X KENSINGTON</u> MARYLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9721 CONNECTICUT AVE.</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>BORNSTEIN</u> Last <u>BORNSTEIN</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 21 1875</u>	
				9. AGE (In years last birthday) <u>83 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CIGAR MAKER-RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	
13. FATHER'S NAME <u>ABRAHAM SHEKTEL</u>				14. MOTHER'S MAIDEN NAME <u>LEAH SHEKTEL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>ROTH BORNSTEIN - DAUGHTER</u> Address <u>9721 CONNECTICUT AVE KENSINGTON MARYLAND</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE HEART FAILURE</u> 422.1 DUE TO <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>AND CARCINOMA OF PROSTATE WITH</u> DUE TO <u>METASTASES</u> (c) INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>20 YEARS</u> <u>8 mos</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>58</u> , to <u>JUNE 6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JUNE 6</u> , 19 <u>58</u> , and that death occurred at <u>11 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7733 ALASKA AVE NW</u> DATE SIGNED ACTUAL SIGNATURE <u>Robert L. Krichmar</u> M.D. <u>WASH 12 D.C.</u> PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>6/9-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Switzland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Goldberg</u> ADDRESS <u>Washington DC</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU ONE TO

One Box No.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES M. JONES		45		M		W		1910		BALTIMORE, MD.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT	
JAN 15 1963		BALTIMORE, MD.		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		DR. J. M. JONES	
TIME OF DEATH		HOURS		MINUTES		SECONDS		TEMPERATURE		PULSE	
10:00 AM		10		00		00		98.6		60	
WEIGHT		HEIGHT		BLOOD PRESSURE		SUGAR		URIC ACID		OTHER	
170 LBS.		5' 10"		120/80		100		5.0			
OCCUPATION		EDUCATION		MARRIAGE		CHILDREN		RELIGION		ETHNIC ORIGIN	
MANAGER		HIGH SCHOOL		MARRIED		3		CATHOLIC		WHITE	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO	
NONE		NONE		NONE		NONE		NONE		NONE	
FAMILY HISTORY		FAMILY HISTORY		FAMILY HISTORY		FAMILY HISTORY		FAMILY HISTORY		FAMILY HISTORY	
NONE		NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF NURSE	

DEATH CERTIFICATE

This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his last illness or who has attended him at the time of death. It should be filled out as soon as possible after death and should be filed in the office of the Registrar of the Department of Health.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6976

CERTIFICATE OF DEATH

06943

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY EASTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton 2040.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				d. STREET ADDRESS 123 West Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frederick Middle Charles Last BOWERFIND				4. DATE OF DEATH Month June Day 21 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 March 1886		9. AGE (In years lost birthday) 72 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Retired		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Frederick BOWERFIND				14. MOTHER'S MAIDEN NAME Lilly SIHLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I, WW-II		17. INFORMANT (Wife) Mrs. Frances C. BOWERFIND (Same as #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.1 METASTATIC CARCINOMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Undifferentiated Carcinoma, Primary in Neck DUE TO (c) 2 YRS INTERVAL BETWEEN ONSET AND DEATH 6 MOS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 June , 19 58 , to 21 June , 19 58 , that I last saw the deceased alive on 21 June , 19 58 , and that death occurred at 11:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE George W. Taylor Jr. M.D. U.S. Naval Hospital, Bethesda, Md. 6-23-58							
PHYSICIAN'S NAME (Type) GEORGE W TAYLOR, JR. CDR, MC, USN U. S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-26-58		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's & Sons 1756 Pennsylvania Ave, NW				24a. REC'D BY REGISTRAR DATE JUN 24 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

6977

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06944

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE FLORIDA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10,707 LOCKRIDGE DRIVE		e. STREET ADDRESS 48 PALMETTO DRIVE	
3. NAME OF DECEASED (Type or print) JOHN WESLEY BOWLBY		4. DATE OF DEATH Month JUNE Day 15 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 15, 1880
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT, retired		10b. KIND OF BUSINESS OR INDUSTRY MEN'S CLOTHING	
11. BIRTHPLACE (State or foreign country) PHILLIPSBURG, N. J.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ROBERT BOWLBY		14. MOTHER'S MAIDEN NAME ELIZABETH JOHNSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 126-12-1410	
17. INFORMANT Mrs. John W. Bowlby		Address 48 Palmetto Dr., Ormond	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROSCART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED June 15, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 6/18/58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY EAST BLOOMFIELD CEMETERY		22d. LOCATION (City, town, or county) (State) EAST BLOOMFIELD, NEW YORK	
23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Pumpfrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE JUN 17 '58		24b. REGISTRAR'S SIGNATURE W. E. Pumpfrey	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Outright

CERTIFICATE OF DEATH

Blank form with horizontal lines for text entry.

RECEIVED
JAN 10 1964
FBI - NEW YORK

Vertical text on the right margin, including "RECEIVED" and "FBI - NEW YORK".

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1c Film G230 6-16-58 et

06946

6979

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 34 3/8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 7800 Wisconsin Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Willard Middle Abner Last Braswell		4. DATE OF DEATH Month June Day 10 Year 19 58					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 14, 1902	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi Driver		10b. KIND OF BUSINESS OR INDUSTRY Passenger Transportation		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Lee Andrew Braswell				14. MOTHER'S MAIDEN NAME Mary Etta Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give year or dates of service) 1920-1923		16. SOCIAL SECURITY NO. 578-26-3702		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure 147X DUE TO Portal Cirrhosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Epidermoid Carcinoma of Hypopharynx (c) 6 mos.				INTERVAL BETWEEN ONSET AND DEATH ? yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 7 , 19 58 , to 10 June , 19 58 , that I last saw the deceased alive on 10 June , 19 58 , and that death occurred at 2:45 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert C. Hoyer, M.D.		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 6/10/58			
PHYSICIAN'S NAME (Type) Robert C. Hoyer, M. D.		National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit		22b. DATE THEREOF 6/11/58		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) St. Augustine, Florida	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR JUN 13 58		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: JOHN J. SMITH</p>		<p>2. Sex: Male</p>	
<p>3. Date of birth: 10/15/1925</p>		<p>4. Place of birth: NEW YORK, N.Y.</p>	
<p>5. Date of death: 11/10/1985</p>		<p>6. Place of death: NEW YORK, N.Y.</p>	
<p>7. Cause of death: Heart Disease</p>		<p>8. Manner of death: Natural</p>	
<p>9. Signature of physician: [Signature]</p>		<p>10. Signature of registrar: [Signature]</p>	
<p>11. Date of registration: 11/15/1985</p>		<p>12. Place of registration: NEW YORK, N.Y.</p>	



NEW YORK STATE DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS
 ALBANY, N.Y.

CERTIFICATE OF DEATH

Reg. Dist. No.

06947

6980

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>8724 Cameron St.</u>			
3. NAME OF DECEASED (Type or print) <u>Ella</u> First <u>Lee</u> Middle <u>Bridger</u> Last				4. DATE OF DEATH <u>June</u> Month <u>1</u> Day <u>19</u> Year <u>58</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 7-1872</u>		9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Lewiston No. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James B. Saunders</u>				14. MOTHER'S MAIDEN NAME <u>Euelyn Barrett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Dr. Roy Bridger</u> <u>1534 East West Highway Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</u> <u>Yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3/22</u> , 19 <u>58</u> , to <u>6/1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5/1</u> , 19 <u>58</u> , and that death occurred at <u>5:28 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. H. Hagan</u>				ADDRESS (Street, city or town, state) <u>Sandy Spring Md</u>		DATE SIGNED <u>6/1/58</u>	
PHYSICIAN'S NAME (Type) <u>C. H. Hagan</u>				M.D. <u>—</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 3</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hoggard Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Lewiston, North Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W. Barber</u> ADDRESS <u>Laytonsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 4 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06948

6981

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington, D.C.</u> b. COUNTY <u>Washington, D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u>		47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		d. STREET ADDRESS <u>3001 Nelson Place, S. E.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>Teresa</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 29, 1954</u>
9. AGE (In years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>25</u> Hours <u>15</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Russell P. Brown</u>		14. MOTHER'S MAIDEN NAME <u>Teresa M. Luskey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mucopurulent tracheobronchitis + bacterial pneumonia</u> 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute lymphocytic leukemia</u> DUE TO (c) <u>10 mos</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 21</u> , 19 <u>58</u> , to <u>June 25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 25</u> , 19 <u>58</u> , and that death occurred at <u>12:50 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward W. Moore</u> M.D.		ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>6/25/58</u>	
PHYSICIAN'S NAME (Type) <u>Edward W. Moore, M. D.</u>		<u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-27-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Elizabeth Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Reginald K. H. 741-11-11 H. S. C.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 30 '58</u>	
ADDRESS <u>H. S. C.</u>		24b. REGISTRAR'S SIGNATURE <u>Reginald K. H.</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6982

CERTIFICATE OF DEATH

06949

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Comus		c. LENGTH OF STAY IN 1b 30 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Wilfred Last Brown		4. DATE OF DEATH Month June Day 19 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 24-1895
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired merchant--Groceries		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas Brown		14. MOTHER'S MAIDEN NAME Albena Kendiz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-34-7258	
17. INFORMANT Mrs Thomas Brown, Comus Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Softening with paralysis + convulsions DUE TO (c) Cerebral Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 3 days 3 years 5 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 491X			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 27 Aug 1951 to 19 June 1958 , that I last saw the deceased alive on 19 June 1958 , and that death occurred at 4:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Barnesville, Maryland DATE SIGNED 6/20/58			
ACTUAL SIGNATURE Gordon M. Smith		M.D. Barnesville, Maryland--6/20/58	
PHYSICIAN'S NAME (Type) Gordon M. Smith			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/21/58	
22c. NAME OF CEMETERY OR CREMATORY Frederick Memorial		22d. LOCATION (City, town, or county) (State) Frederick, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Helton		ADDRESS Barnesville, Md	
24a. REC'D BY REGISTRAR JUN 23 58		24b. REGISTRAR'S SIGNATURE W. B. Helton	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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8067-89 10

1998-1999

*chr2: chr2:15

2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808 2809 2810 2811 2812 2813 2814 2815 2816 2817 2818 2819 2820 2821 2822

6983

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>1127 Grandin Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>J.</u> Last <u>Burke</u>		4. DATE OF DEATH Month <u>6</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 1, 1911</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>5</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cartographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Army Map Service</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hubert Burke</u>		14. MOTHER'S MAIDEN NAME <u>Bridget Caulfield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>067-05-8600</u>	
17. INFORMANT <u>Rita J. Burke</u>		Address <u>Widow</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhage, right hemisphere</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 10, 1958</u> to <u>June 6, 1958</u> , that I last saw the deceased alive on <u>June 6, 1958</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Bonditch Hunter, Jr., M.D.</u>		ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd., Rockville</u>	
DATE SIGNED <u>6/7/1958</u>			
PHYSICIAN'S NAME (Type) <u>G. Bonditch Hunter, Jr., M.D.</u>		<u>809 Viers Mill Rd., Rockville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/10/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 10 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-50-70

16711

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6960

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville,</u>				c. LENGTH OF STAY IN 1b <u>26</u> <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>100 North Grandin Avenue</u>				d. STREET ADDRESS <u>100 North Grandin Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>E.</u> Last <u>BURROUGHS</u>				4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/27/1902</u>	
9. AGE (In years lost birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>20</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Pat Connelly</u>				14. MOTHER'S MAIDEN NAME <u>Annie Hendy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT Address <u>Daughter</u> <u>Catherine Elliott-Brooms Island, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>Adenocarcinoma of Rectum</u> <u>154x</u> DUE TO <u>with generalized metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>26 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>October</u> , 19 <u>56</u> , to <u>6/17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/17</u> , 19 <u>58</u> , and that death occurred at <u>12:10 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur F. Woodward</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>41 W. Wood Lane, Rockville, Md. 6/17/58</u>			
PHYSICIAN'S NAME (Type) <u>Arthur F. Woodward</u>				<u>41 W. Wood Lane, Rockville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Darnestown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUN 18 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6080

DATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF BIRTH		8. PLACE OF DEATH		9. CAUSE OF DEATH	
10. MEDICAL HISTORY		11. PRESENT ILLNESS		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF REGISTRAR	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF BURIAL PLACE		18. SIGNATURE OF INTERVIEWER	
19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF INTERVIEWER		21. SIGNATURE OF INTERVIEWER	
22. SIGNATURE OF INTERVIEWER		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWER	
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97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWER		99. SIGNATURE OF INTERVIEWER	
100. SIGNATURE OF INTERVIEWER		101. SIGNATURE OF INTERVIEWER		102. SIGNATURE OF INTERVIEWER	

DEATH CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6984

CERTIFICATE OF DEATH

Reg. Dist. No.

06952

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9706 Bellevue Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ELMON</u> First <u>Larmer</u> Middle <u>BURTON</u> Last				4. DATE OF DEATH <u>June 3</u> 19 <u>58</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 27, 1875</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>6</u>		IF UNDER 24 HRS. Hours <u>5</u> Min. <u>6</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mfg.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Draperies, etc.</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>Richard Moore Burton</u>				14. MOTHER'S MAIDEN NAME <u>Mary Creighton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>677-48-7505A</u>		17. INFORMANT Address <u>Mrs. Geo. Caldwell- same as 2d</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Cerebral Occlusion Route</u> DUE TO <u>Cerebral Occlusion Route</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Occlusion Route</u> DUE TO <u>Cerebral Occlusion Route</u> (c) <u>Cerebral Occlusion Route</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>yr</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 15</u> , 19 <u>56</u> to <u>June 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5/30/58</u> , 19 <u>58</u> , and that death occurred on <u>June 3</u> , 19 <u>58</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel Allen, M.D.</u>				DATE SIGNED <u>6/2/58</u>			
PHYSICIAN'S NAME (Type) <u>Samuel Allen, MD</u>				<u>Kensington, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>June 9 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Allen</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

DATE OF DEATH

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. EDUCATION</p> <p>9. RELIGION</p> <p>10. RACE</p> <p>11. COLOR</p> <p>12. ETHNIC ORIGIN</p> <p>13. SOCIAL SECURITY NUMBER</p> <p>14. HOME ADDRESS</p> <p>15. CITY</p> <p>16. STATE</p> <p>17. ZIP CODE</p> <p>18. TELEPHONE NUMBER</p> <p>19. MOTHER'S MAIDEN NAME</p> <p>20. FATHER'S NAME</p> <p>21. MOTHER'S NAME</p> <p>22. FATHER'S NAME</p> <p>23. MOTHER'S NAME</p> <p>24. FATHER'S NAME</p> <p>25. MOTHER'S NAME</p> <p>26. FATHER'S NAME</p> <p>27. MOTHER'S NAME</p> <p>28. FATHER'S NAME</p> <p>29. MOTHER'S NAME</p> <p>30. FATHER'S NAME</p> <p>31. MOTHER'S NAME</p> <p>32. FATHER'S NAME</p> <p>33. MOTHER'S NAME</p> <p>34. FATHER'S NAME</p> <p>35. MOTHER'S NAME</p> <p>36. FATHER'S NAME</p> <p>37. MOTHER'S NAME</p> <p>38. FATHER'S NAME</p> <p>39. MOTHER'S NAME</p> <p>40. FATHER'S NAME</p> <p>41. MOTHER'S NAME</p> <p>42. FATHER'S NAME</p> <p>43. MOTHER'S NAME</p> <p>44. FATHER'S NAME</p> <p>45. MOTHER'S NAME</p> <p>46. FATHER'S NAME</p> <p>47. MOTHER'S NAME</p> <p>48. FATHER'S NAME</p> <p>49. MOTHER'S NAME</p> <p>50. FATHER'S NAME</p> <p>51. MOTHER'S NAME</p> <p>52. FATHER'S NAME</p> <p>53. MOTHER'S NAME</p> <p>54. FATHER'S NAME</p> <p>55. MOTHER'S NAME</p> <p>56. FATHER'S NAME</p> <p>57. MOTHER'S NAME</p> <p>58. FATHER'S NAME</p> <p>59. MOTHER'S NAME</p> <p>60. FATHER'S NAME</p> <p>61. MOTHER'S NAME</p> <p>62. FATHER'S NAME</p> <p>63. MOTHER'S NAME</p> <p>64. FATHER'S NAME</p> <p>65. MOTHER'S NAME</p> <p>66. FATHER'S NAME</p> <p>67. MOTHER'S NAME</p> <p>68. FATHER'S NAME</p> <p>69. MOTHER'S NAME</p> <p>70. FATHER'S NAME</p> <p>71. MOTHER'S NAME</p> <p>72. FATHER'S NAME</p> <p>73. MOTHER'S NAME</p> <p>74. FATHER'S NAME</p> <p>75. MOTHER'S NAME</p> <p>76. FATHER'S NAME</p> <p>77. MOTHER'S NAME</p> <p>78. FATHER'S NAME</p> <p>79. MOTHER'S NAME</p> <p>80. FATHER'S NAME</p> <p>81. MOTHER'S NAME</p> <p>82. FATHER'S NAME</p> <p>83. MOTHER'S NAME</p> <p>84. FATHER'S NAME</p> <p>85. MOTHER'S NAME</p> <p>86. FATHER'S NAME</p> <p>87. MOTHER'S NAME</p> <p>88. FATHER'S NAME</p> <p>89. MOTHER'S NAME</p> <p>90. FATHER'S NAME</p> <p>91. MOTHER'S NAME</p> <p>92. FATHER'S NAME</p> <p>93. MOTHER'S NAME</p> <p>94. FATHER'S NAME</p> <p>95. MOTHER'S NAME</p> <p>96. FATHER'S NAME</p> <p>97. MOTHER'S NAME</p> <p>98. FATHER'S NAME</p> <p>99. MOTHER'S NAME</p> <p>100. FATHER'S NAME</p>		<p>1. CAUSE OF DEATH</p> <p>2. MANNER OF DEATH</p> <p>3. PLACE OF DEATH</p> <p>4. TIME OF DEATH</p> <p>5. DATE OF DEATH</p> <p>6. TIME OF DEATH</p> <p>7. DATE OF DEATH</p> <p>8. TIME OF DEATH</p> <p>9. DATE OF DEATH</p> <p>10. TIME OF DEATH</p> <p>11. DATE OF DEATH</p> <p>12. TIME OF DEATH</p> <p>13. DATE OF DEATH</p> <p>14. TIME OF DEATH</p> <p>15. DATE OF DEATH</p> <p>16. TIME OF DEATH</p> <p>17. DATE OF DEATH</p> <p>18. TIME OF DEATH</p> <p>19. DATE OF DEATH</p> <p>20. TIME OF DEATH</p> <p>21. DATE OF DEATH</p> <p>22. TIME OF DEATH</p> <p>23. DATE OF DEATH</p> <p>24. TIME OF DEATH</p> <p>25. DATE OF DEATH</p> <p>26. TIME OF DEATH</p> <p>27. DATE OF DEATH</p> <p>28. TIME OF DEATH</p> <p>29. DATE OF DEATH</p> <p>30. TIME OF DEATH</p> <p>31. DATE OF DEATH</p> <p>32. TIME OF DEATH</p> <p>33. DATE OF DEATH</p> <p>34. TIME OF DEATH</p> <p>35. DATE OF DEATH</p> <p>36. TIME OF DEATH</p> <p>37. DATE OF DEATH</p> <p>38. TIME OF DEATH</p> <p>39. DATE OF DEATH</p> <p>40. TIME OF DEATH</p> <p>41. DATE OF DEATH</p> <p>42. TIME OF DEATH</p> <p>43. DATE OF DEATH</p> <p>44. TIME OF DEATH</p> <p>45. DATE OF DEATH</p> <p>46. TIME OF DEATH</p> <p>47. DATE OF DEATH</p> <p>48. TIME OF DEATH</p> <p>49. DATE OF DEATH</p> <p>50. TIME OF DEATH</p> <p>51. DATE OF DEATH</p> <p>52. TIME OF DEATH</p> <p>53. DATE OF DEATH</p> <p>54. TIME OF DEATH</p> <p>55. DATE OF DEATH</p> <p>56. TIME OF DEATH</p> <p>57. DATE OF DEATH</p> <p>58. TIME OF DEATH</p> <p>59. DATE OF DEATH</p> <p>60. TIME OF DEATH</p> <p>61. DATE OF DEATH</p> <p>62. TIME OF DEATH</p> <p>63. DATE OF DEATH</p> <p>64. TIME OF DEATH</p> <p>65. DATE OF DEATH</p> <p>66. TIME OF DEATH</p> <p>67. DATE OF DEATH</p> <p>68. TIME OF DEATH</p> <p>69. DATE OF DEATH</p> <p>70. TIME OF DEATH</p> <p>71. DATE OF DEATH</p> <p>72. TIME OF DEATH</p> <p>73. DATE OF DEATH</p> <p>74. TIME OF DEATH</p> <p>75. DATE OF DEATH</p> <p>76. TIME OF DEATH</p> <p>77. DATE OF DEATH</p> <p>78. TIME OF DEATH</p> <p>79. DATE OF DEATH</p> <p>80. TIME OF DEATH</p> <p>81. DATE OF DEATH</p> <p>82. TIME OF DEATH</p> <p>83. DATE OF DEATH</p> <p>84. TIME OF DEATH</p> <p>85. DATE OF DEATH</p> <p>86. TIME OF DEATH</p> <p>87. DATE OF DEATH</p> <p>88. TIME OF DEATH</p> <p>89. DATE OF DEATH</p> <p>90. TIME OF DEATH</p> <p>91. DATE OF DEATH</p> <p>92. TIME OF DEATH</p> <p>93. DATE OF DEATH</p> <p>94. TIME OF DEATH</p> <p>95. DATE OF DEATH</p> <p>96. TIME OF DEATH</p> <p>97. DATE OF DEATH</p> <p>98. TIME OF DEATH</p> <p>99. DATE OF DEATH</p> <p>100. TIME OF DEATH</p>
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MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06953

Reg. Dist. No.

6940

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONT.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA WHEATON MD				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X WHEATON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSP. T.P.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ORA Middle GALEN Last CARNES				4. DATE OF DEATH Month 6 Day 19 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-27-84	
9. AGE (In years lost birthday) 74 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINISTER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) OHIO Illinois	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JOHN H. CARNES			
14. MOTHER'S MAIDEN NAME CAROLINE PERSOON				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO			
16. SOCIAL SECURITY NO.				17. INFORMANT HOSP. RECORDS. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitral and Coronary 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of Colon (c)							INTERVAL BETWEEN ONSET AND DEATH 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 11 p. m. Month 19 Day Year				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from June 2 , 1958, to June 19 , 1958, that I last saw the deceased alive on June 19 , 1958, and that death occurred at 10:20 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Michael Dobridge				ADDRESS (Street, city or town, state) 10620 GEORGETOWN AVE. LEBANON, MD. DATE SIGNED June 19, 1958			
PHYSICIAN'S NAME (Type) MICHAEL DOBRIDGE				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF June 23, 1958				22c. NAME OF CEMETERY OR CREMATORY Parkland Cemetery			
22d. LOCATION (City, town, or county) Montgomery County (State) MD.				23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters ADDRESS 254 Carroll Street N.C.			
24a. REC'D BY REGISTRAR JUN 20 '58				24b. REGISTRAR'S SIGNATURE Robert Smith			

6985

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 23040 King Highway	
3. NAME OF DECEASED (Type or print) First Thomas Middle Homer Last CARR		4. DATE OF DEATH Month June Day 7 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-6-58
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Homer Judson CARR		14. MOTHER'S MAIDEN NAME Shirley Louise HALL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Homer J. Carr (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hyaline Membrane Dis. + Prematurity (c) 32 hours		INTERVAL BETWEEN ONSET OF DEATH 32 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-6- 19 58 , to 6-7- 19 58 , that I last saw the deceased alive on 7 June 19 58 , and that death occurred at 10:00 A. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. C. Parke, Jr.		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE 6-7-58	
PHYSICIAN'S NAME (Type) J. C. PARKE, JR., LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-11-58	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Harrisonburg, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumpfrey, 1557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR JUN 10 58	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

06955

Reg. Dist. No.

6941

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Hilda Ruth Chain</u>				4. DATE OF DEATH <u>June 30 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-6-98</u>	
9. AGE (In years lost birthday) <u>60 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Arthur C. Eckert</u>			
14. MOTHER'S MAIDEN NAME <u>Anna Roth</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>Yes</u>				17. INFORMANT <u>Patient</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Infarct</u> DUE TO (c) <u>Pulmonary Infarct</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>3 years</u> <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>X X X</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>A.M.</u>	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>June 1, 1955</u> , to <u>June 30, 1958</u> , that I last saw the deceased alive on <u>June 30, 1958</u> , and that death occurred at <u>10:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Hare</u>				ADDRESS (Street, city or town, state) <u>809 Davis Ave., T.P. Md.</u> DATE SIGNED <u>6/30/58</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>				ADDRESS <u>809 Davis Ave., T.P. Md.</u> DATE <u>6/30/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HANOVER, PENNSYLVANIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>JUL 2 58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. E. Humphrey</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No. 215

6986

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Virginia		b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 39 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria		83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 141 No. Grayson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas Spearman COATS		First Middle Last		4. DATE OF DEATH Month Day Year June 13 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 13, 1916	
9. AGE (In years last birthday) 41 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Louisiana	
13. FATHER'S NAME Lewis Leavell COATS				14. MOTHER'S MAIDEN NAME Clyde SPEARMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW11 -Korean		17. INFORMANT (W) Elmay J. Coats, same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Biliary duct Carcinoma with extensive hepatic metastasis 155.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 months					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 6 19 58 to June 13 19 58 , that I lost s/he the deceased on June 13 1958 , and that death occurred at 6:47P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NMMC DATE SIGNED 6-14-58 ACTUAL SIGNATURE R. P. DOBBIE, JR. M.D. PHYSICIAN'S NAME (Type) R. P. DOBBIE, JR., CDR, MC, USN Bethesda, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-18-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Demaine Funeral Home, 520 So. Washington St.				24a. REC'D BY REGISTRAR DATE JUN 16 58		24b. REGISTRAR'S SIGNATURE R. P. DOBBIE, JR.	

VS A15 (4)
15M 10/57

VS A15 (4)
15M 10/57

STATE DEPARTMENT OF HEALTH-BIRMINGHAM

CERTIFICATE OF DEATH

06957

Reg. Dist. No. 215

6987

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia D.C.	
b. CITY OR TOWN (If outside corporate limits, write Bethesda (Rural))		c. CITY OR TOWN (If outside corporate limits, write Washington)	
d. NAME OF HOSPITAL (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 3101 Sherman Ave., N.W.	
3. NAME OF DECEASED (Type or print) First Pauline Middle Edward Last COLEMAN		4. DATE OF DEATH Month June Day 19 Year 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH January 4, 1911
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edward Brown		14. MOTHER'S MAIDEN NAME Lily Campbell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 6000 DUE TO Chronic Pyelonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Pyelonephritis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 May , 19 58 , to 19 June , 19 58 , that I last saw the deceased alive on 19 June , 19 58 , and that death occurred at 11:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. G. Muth		DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 6-20-58	
PHYSICIAN'S NAME (Type) R.G. Muth, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-24-58	22c. NAME OF CEMETERY OR CREMATORY Family Cemetery	22d. LOCATION (City, town, or county) (State) Broad Run, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Joynes Funeral Home, 116 Mass Ave., Wash. D.C.		24a. REC'D BY REGISTRAR JUN 24 '58	24b. REGISTRAR'S SIGNATURE W. L. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8&9

Film G231 7/21/58

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06958

Reg. Dist. No.

FOR STATE
HEALTH DEPT.1. PLACE OF DEATH
a. COUNTY

6942

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE

md

b. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN 1b

3 mo

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

17 Takoma Park 12

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Fair Hill Nursing Home

d. STREET ADDRESS

903 Kennebec Avenue

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)

Beessie R Cosner

4. DATE
OF
DEATH

June 25 1958

5. SEX

Female

6. COLOR OR RACE

white

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

1882

9. AGE (in years
last birthday)

75.76 yrs.

10. UNDER 1 YEAR

Months Days Hours Min.

11. UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

W. Va

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Lemuel Kammell

14. MOTHER'S MAIDEN NAME

Sophia Salwick

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Nursing Home Record

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

DUE TO

Coronary occlusion

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

hypertension

DUE TO

C.V.A.

(c)

INTERVAL BETWEEN
ONSET AND DEATH

sudden

years

1 yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour a. m.
p. m.

19

20d. INJURY OCCURRED
While at work ☐ Not while at work ☐20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☒. and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐ACTUAL
SIGNATURE

Frank J. Brosch

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S
NAME (Type)

FRANK J. Brosch

ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

6-25-58

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

June 28, 1958

22c. NAME OF CEMETERY OR CREMATORY

Queens Point Cemetery

22d. LOCATION (City, town, or county)

Medical County, West Virginia

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

J. Arthur Wallis, 254 Carroll N.W. D.C.

24a. REC'D BY REGISTRAR

DATE JUN 27 '58

24b. REGISTRAR'S SIGNATURE

W. J. Smith

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND
DEPARTMENT OF HEALTH

1942

1. NAME OF DECEASED: John Doe
2. SEX: Male
3. AGE: 45
4. OCCUPATION: Teacher
5. PLACE OF BIRTH: Washington, D.C.
6. DATE OF BIRTH: Jan 15, 1897
7. MARITAL STATUS: Married
8. PLACE OF DEATH: Home
9. DATE OF DEATH: Dec 10, 1942
10. TIME OF DEATH: 10:30 AM
11. CAUSE OF DEATH: Myocardial Infarction
12. MANNER OF DEATH: Natural
13. SIGNATURE OF EXAMINER: [Signature]
14. TITLE OF EXAMINER: Medical Examiner
15. ADDRESS OF EXAMINER: 123 Main St, Baltimore, Md.

16. HISTORY OF PRESENT ILLNESS: Onset of chest pain and shortness of breath on Dec 8, 1942, at home. Pain radiated to left arm and jaw. No vomiting or diarrhea. Last meal on Dec 7, 1942.
17. PREVIOUS ILLNESSES: None reported.
18. MEDICATIONS: None.
19. ALLERGIC REACTIONS: None.
20. SOCIAL HISTORY: Non-smoker. No alcohol consumption.

21. PHYSICAL EXAMINATION: On admission to hospital, patient was found unconscious. Pupils were equal and reactive. Heart rate was 120 bpm, regular. Blood pressure was 180/110 mmHg. No murmurs, rubs, or gallops. Lungs were clear. Abdomen was soft and non-tender. No bowel sounds. Extremities were cool and cyanotic.
22. LABORATORY TESTS: None performed.
23. X-RAY EXAMINATIONS: None performed.
24. OTHER TESTS: None performed.
25. POST-MORTEM EXAMINATION: Not performed.
26. SIGNATURE OF EXAMINER: [Signature]
27. TITLE OF EXAMINER: Medical Examiner
28. ADDRESS OF EXAMINER: 123 Main St, Baltimore, Md.

6988

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 44 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 821 Oglethorpe Street, N. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle Patricia Last Craven		4. DATE OF DEATH Month June Day 12 Year 1958					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 9, 1929	9. AGE (In years last birthday) 28 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Typist		10b. KIND OF BUSINESS OR INDUSTRY Insurance Office		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter McLister				14. MOTHER'S MAIDEN NAME Lillian Robertson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-36-0579		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Melanoma 190.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 3 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 29, 1958 , to June 12, 1958 , that I last saw the deceased alive on June 12, 1958 , and that death occurred at 10:10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dane R. Boggs		M.D. The Clinical Center		DATE SIGNED 6/12/58			
PHYSICIAN'S NAME (Type) Dane R. Boggs, M. D.		National Institutes of Health		Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-16-58		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Montgomery & Md	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Huntman and Son		ADDRESS 15732 Ave Georgia		24a. REC'D BY REGISTRAR JUN 13 '58		24b. REGISTRAR'S SIGNATURE W. H. Huntman	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1908

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1863		Maryland	
Usual Residence		Occupation		Cause of Death		Date of Death		Place of Death	
123 Main St		Farmer		Heart Disease		Jan 15, 1908		Home	
Physician		Medical Attendant		Burial Place		Time of Day		Month and Year	
Dr. Smith		J. Doe		Cemetery		10:00 AM		Jan 1908	
Signature of Physician		Signature of Medical Attendant		Signature of Burial Officer		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECORDED

10 HOURS OF VARIOUS EMPLOYERS

6989

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Scotland		c. LENGTH OF STAY IN life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Scotland rural	
		d. STREET ADDRESS RFD Rockville	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bertha Middle Dove Last Crawford		4. DATE OF DEATH Month June Day 24 Year 1958	
5. SEX fem	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30 1871
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		Maryland	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry Dove		14. MOTHER'S MAIDEN NAME Mary Ann Dove	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
		17. INFORMANT Eddington Crawford, Seven Looks Rd., Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Cerebral Thrombosis or Embolism 442X DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). DUE TO Arteriosclerotic Cardiorenal Disease (c).		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Sarcoma Bilateral Breasts Refused surgery 1950.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 14, 1949 , to June 24, 1958 , that I last saw the deceased alive on June 24, 1958 , and that death occurred at 6:50 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) RFD 1 Silver Spring, Md.	
ACTUAL SIGNATURE Webster Sewell M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) Webster Sewell, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/28/58	22c. NAME OF CEMETERY OR CREMATORY Lincoln Park.,	22d. LOCATION (City, town, or county) (State) Rockville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sawdley		24a. REC'D BY REGISTRAR DATE JUL 7 '58	24b. REGISTRAR'S SIGNATURE W. L. Sawdley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 7, Film G231, 7/10/58
6990
CERTIFICATE OF DEATH

06961

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Mont. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda, Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>10209-Tyburn Terrace</i>	
3. NAME OF DECEASED (Type or print) First <i>Grace</i> Middle <i>J. Cunningham</i> Last <i>Cunningham</i>		4. DATE OF DEATH Month <i>June</i> Day <i>28</i> Year <i>1958</i>	
5. SEX <i>f</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 15, 1881</i>
9. AGE (In years last birthday) <i>77</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>owner of millinery shop - retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>retired</i>	
11. BIRTHPLACE (State or foreign country) <i>Missouri</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Robert Shields</i>		14. MOTHER'S MAIDEN NAME <i>Tamina Valentin</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>James A. Cunningham - son</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PULMONARY INFARCTION</i> <i>465x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>PULMONARY EMBOLI</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <i>TWO DAYS</i> <i>TWO DAYS</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June 26</i> , 19 <i>58</i> , to <i>June 28</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>June 28</i> , 19 <i>58</i> , and that death occurred at <i>1:25 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Joseph R. Connor</i> M.D.		ADDRESS (Street, city or town, state) <i>9420 Old Georgetown Rd. Bethesda, Md</i>	
DATE SIGNED <i>28 June 1958</i>			
PHYSICIAN'S NAME (Type) <i>Bethesda H. Maryland</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-2-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt Hope Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Chicago Ill</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Deaf Funeral Home</i> ADDRESS <i>4812 Adams Ave</i>		24a. REC'D BY REGISTRAR <i>W. H. W.</i>	24b. REGISTRAR'S SIGNATURE <i>W. H. W.</i>
DATE <i>JUL 2 '58</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6991

CERTIFICATE OF DEATH

06962

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN TB <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>4615 Harling Lane</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>G.</u> Last <u>Currier</u>				4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 5, 1868</u>	
9. AGE (In years lost birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>14</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Gillette</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>(Son) Rodney Currier - Same as 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>792x</u> <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sanitation</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb</u> 19 <u>52</u> to <u>June 19</u> 19 <u>58</u> , that I last saw the deceased alive on <u>June 19</u> 19 <u>58</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Alfred S. Norton</u>				ADDRESS (Street, city or town, state) <u>4711 Highland Ave. Beth. Md</u> DATE SIGNED <u>6/20/58</u>			
PHYSICIAN'S NAME (Type) <u>Alfred S. Norton</u>				<u>4711 Highland Ave. Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/23/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>JUN 23 '58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>W. A. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6992

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <u>Frank</u> Middle <u>W</u> Last <u>Dahn</u>		4. DATE OF DEATH		Month <u>June</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 17-1879</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Patent Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>August Dahn</u>				14. MOTHER'S MAIDEN NAME <u>Wilhelmia Kruger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes-Unknown</u>		17. INFORMANT <u>Norrine N. Dahn</u>		Address <u>same as 2d</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular Renal Disease</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Typhoid Fever</u> DUE TO (c) <u>10 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Many Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> 19 <u>57</u> to <u>June 2</u> 19 <u>58</u> that I last saw the deceased alive on <u>June 1</u> 19 <u>58</u> and that death occurred at <u>10 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chevy Chase 15 Md</u> DATE SIGNED <u>Bradley D. Hodgkins</u>							
ACTUAL SIGNATURE <u>Bradley D. Hodgkins</u> M.D.				4413 <u>Bradley Lane</u>			
PHYSICIAN'S NAME (Type) <u>Bradley D. Hodgkins, MD</u>				<u>Chevy Chase 15 Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Beallsville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>JUN 4 58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED ROBERT A. LAMOND		2. SEX MALE		3. AGE 62	
4. DATE OF DEATH APRIL 12 1962		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH HOME	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH NATURAL		9. ICD-9 CODE 410.9	
10. SIGNATURE OF PHYSICIAN <i>Robert A. Lamond</i>		11. SIGNATURE OF REGISTRAR <i>Robert A. Lamond</i>		12. SIGNATURE OF WITNESS <i>Robert A. Lamond</i>	
13. SIGNATURE OF DECEASED <i>Robert A. Lamond</i>		14. SIGNATURE OF NEXT OF KIN <i>Robert A. Lamond</i>		15. SIGNATURE OF BURIAL OFFICIAL <i>Robert A. Lamond</i>	
16. SIGNATURE OF CHURCH OFFICIAL <i>Robert A. Lamond</i>		17. SIGNATURE OF FUNERAL HOME <i>Robert A. Lamond</i>		18. SIGNATURE OF CEMETERY <i>Robert A. Lamond</i>	
19. SIGNATURE OF CORONER <i>Robert A. Lamond</i>		20. SIGNATURE OF JURY <i>Robert A. Lamond</i>		21. SIGNATURE OF JUDGE <i>Robert A. Lamond</i>	
22. SIGNATURE OF DISTRICT ATTORNEY <i>Robert A. Lamond</i>		23. SIGNATURE OF COUNTY CLERK <i>Robert A. Lamond</i>		24. SIGNATURE OF STATE DEPARTMENT OF HEALTH <i>Robert A. Lamond</i>	

CERTIFICATE OF DEATH

Item 8, Film G-233 9/17/58, cac.

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE PENNSYLVANIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 20 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Rotzell Last Davey				4. DATE OF DEATH Month June Day 15 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 23, 1921 June 21, 1921	
9. AGE (In years lost birthday) 36 yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) College Professor				10b. KIND OF BUSINESS OR INDUSTRY Education		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Samuel Davey			
14. MOTHER'S MAIDEN NAME Grace Rotzell				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			
16. SOCIAL SECURITY NO. WW II				17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 178X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic choriodcarcinoma DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs 2 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from May 26 19 58 to June 15 19 58 , that I last saw the deceased alive on June 15 19 58 , and that death occurred at 9:55 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward W. Moore M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 6-15-58			
PHYSICIAN'S NAME (Type) Edward W. Moore, M. D.				The National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/17/58		22c. NAME OF CEMETERY OR CREMATORY Center County Memorial		22d. LOCATION (City, town, or county) (State) College Township, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE JUN 18 '58		24b. REGISTRAR'S SIGNATURE Overland	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6993

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE N.Y. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b 4 mos			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private home				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) Charles Henry Davis, Sr.				4. DATE OF DEATH June 9 1958			
5. SEX male		6. COLOR OR RACE C		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 1, 1889	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY Electric Co. Maryland			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Joseph Davis				14. MOTHER'S MAIDEN NAME Josephine Warfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Carrie L. Davis				Address 4021 Plyers Mill Rd., Kensington, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coma Acidosis 442x DUE TO Hemiplegia Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis Cardiorenal Disease (c) 4 mos. INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) June 9 1958				(County) (State)			
21. I certify that I attended the deceased from March 10 1958 to June 9 1958 , that I last saw the deceased alive on June 8 1958 , and that death occurred at 3:10 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Webster Sewell				DATE SIGNED June 6 1958			
PHYSICIAN'S NAME (Type) Webster Sewell, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/12/58		22c. NAME OF CEMETERY OR CREMATORY Ash Memorial,		22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR June 16 '58	
				24b. REGISTRAR'S SIGNATURE Carl Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06966

6994

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN TB 5 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10423 Foscett St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MYRA Middle NAOMI Last DELAUTER		4. DATE OF DEATH Month June Day 29 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1977
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 29 Days 29 Hours 19 Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME J. Newton Whipp		14. MOTHER'S MAIDEN NAME Ann Maria Shellman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk	
17. INFORMANT M. Josephine DeLauter		Address (Same as item #1)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 33/x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) years		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 10, 1954 to June 29, 1958 , that I last saw the deceased alive on June 29, 1958 , and that death occurred at 8:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John J. Curry M.D.		ADDRESS (Street, city or town, state) 10620 Georgian Ave	
PHYSICIAN'S NAME (Type) Silver Spring, Md.		DATE SIGNED 6/29/58	
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF July 2, 1958	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Md.	
23. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son; Frederick, Md.		ADDRESS Frederick	
24a. REC'D BY REGISTRAR DATE JUL 1 '58		24b. REGISTRAR'S SIGNATURE Alb. Smith	

CERTIFICATE OF DEATH

Form No. 10

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
JAMES H. HARRIS		65		M		W		C	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
1000 N. E. ST.		JAN 10 1910		HOME		HEART DISEASE		NATURAL	
OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		HISTORY	
Carpenter		8		M		None		None	
BIRTH		DATE OF BIRTH		PLACE OF BIRTH		PARENTS		Siblings	
JAN 10 1845		JAN 10 1845		MD		JAMES H. HARRIS		None	
FATHER		MOTHER		GRANDFATHER		GRANDMOTHER		Other Relatives	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		None	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Minister		Signature of Undertaker	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death	
JAN 10 1910		10:00 AM		HOME		HEART DISEASE		NATURAL	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Minister		Signature of Undertaker	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

6995

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C. 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 3200 Oliver St. N.W.			
3. NAME OF DECEASED (Type or print) First Middle Last Joseph B. DeLozier				4. DATE OF DEATH Month Day Year June 23 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 29 1889	
9. AGE (In years lost birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Linus De Lozier				14. MOTHER'S MAIDEN NAME Gutwald			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT Daughter	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 7 hrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 23, 1958 , to June 23, 1958 , that I last saw the deceased alive on June 23, 1958 , and that death occurred at 8:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert B. Havell				ADDRESS (Street, city or town, state) DATE SIGNED 5516 Nebraska Ave. N.E. 6/23/58			
PHYSICIAN'S NAME (Type) Robert B. Havell							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/25/58		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		22d. LOCATION (City, town, or county) (State) Bethesda Md	
23. FUNERAL DIRECTOR'S SIGNATURE Cherry Chase				ADDRESS Funeral Home Wash. D.C.		24a. REC'D BY REGISTRAR DATE JUN 26 '58	
				24b. REGISTRAR'S SIGNATURE W. H. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6996

Reg. Dist. No. **06968**

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> c. LENGTH OF STAY IN 1b <u>DOA</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Rt. #2</u> d. STREET ADDRESS <u>Coleville Road</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery County General Hosp</u>				4. DATE OF DEATH Month <u>6</u> Day <u>21</u> Year <u>58</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Devilbiss</u> Last <u>Devilbiss</u>				5. SEX <u>Male</u>				6. COLOR OR RACE <u>White</u>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-14-88</u>		9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Samuel Devilbiss</u>				14. MOTHER'S MAIDEN NAME <u>Susan Easton</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>Lena Devilbiss</u>				Address <u>same as #2</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Corcorney conclusion:</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6-21-58</u>						DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>6/23/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>				22d. LOCATION (City, town, or county) (State) <u>Riggs, Road, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W Barber</u>						ADDRESS <u>Laytonsville, Md.</u>				24a. REC'D BY REGISTRAR <u>JUN 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Enoch</u>	

513.

[illegible]

6997

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Georgia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 26 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 304 East 67th Street			
3. NAME OF DECEASED (Type or print) First Shirley Middle Naomi Last Dinerman				4. DATE OF DEATH Month June Day 13 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 23, 1919	
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Harry Marcus				14. MOTHER'S MAIDEN NAME Tillie Mintz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 260-01-7421		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) post operative cardiac surgery DUE TO (c) congenital aortic stenosis						INTERVAL BETWEEN ONSET AND DEATH 90 min 10 days life	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 18, 1958 , to June 13, 1958 , that I last saw the deceased alive on June 13, 1958 , and that death occurred at 1:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 6/13/58 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE James C. Allen M.D. PHYSICIAN'S NAME (Type) James C. Allen, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/16-1958		22c. NAME OF CEMETERY OR CREMATORY Bonaventure Cem		22d. LOCATION (City, town, or county) (State) Savannah Ga	
23. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home ADDRESS Colts. DC				24a. REC'D BY REGISTRAR DATE JUN 16 '58		24b. REGISTRAR'S SIGNATURE W. J. Couch	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6998

CERTIFICATE OF DEATH

Reg. Dist. No.

215

06970

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3	
f. STREET ADDRESS 133 "E" Street, N.W.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Joseph Last EAGLE		4. DATE OF DEATH Month June Day 20 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Feb. 1882
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps (Ret.)	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 8 June , 19 58 , to 20 June , 19 58 , that I last saw the deceased alive on 19 June , 19 58 , and that death occurred at 4:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE G. E. Gorsuch, Lt MC USN		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) G. E. GORSUCH, LT, MC, USN		DATE SIGNED 6-20-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-24-58	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery
22d. LOCATION (City, town, or county) Arlington, Virginia		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE R. T. RYAN, 317 PENN. AVE. WASHINGTON, D.C.		24a. REC'D BY REGISTRAR JUN 23 '58	
24b. REGISTRAR'S SIGNATURE G. E. Gorsuch			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06971

6943

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>A.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seabrook Park</u>	c. LENGTH OF STAY IN 1b <u>4 mths</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>517 Albany Avenue</u>		d. STREET ADDRESS <u>938 C ST. S.W.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>D.</u> Last <u>FARRAR</u>		4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 15, 1873</u>
9. AGE (In years last birthday) <u>18.5</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Eng. U.S. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Alexandria, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Heasley</u>		14. MOTHER'S MAIDEN NAME <u>Emeline Heasley Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Ms. Rev. J. McCloskey, Silver Spring, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular disease, Debility</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. 11.</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>22 June, 1958</u> to <u>23 June, 1958</u> that I last saw the deceased alive on <u>23 June, 1958</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas P. Fogarty</u>		ADDRESS (Street, city or town, state) <u>1011 University Blvd E, Silver Spring Md.</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS P. FOGARTY</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 26, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Alexandria, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Walters</u>		ADDRESS <u>254 Carroll 21 Mt. St.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>	

CERTIFICATE OF DEATH

Coroner notified
 And will approve
 H. H. H. H.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6999

CERTIFICATE OF DEATH

Reg. Dist. No.

06972

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Florence Middle Duncan Last Feldman		4. DATE OF DEATH Month June Day 16 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 26, 1924
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None -Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 33 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) New York, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Pincus Duncan		14. MOTHER'S MAIDEN NAME Miriam Ottenstein	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-20-3155	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) UREMIA DUE TO (c) chronic glomerulonephritis INTERVAL BETWEEN ONSET AND DEATH minutes 2 years 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15, 19 58 , to June 16, 19 58 , that I last saw the deceased alive on June 16, 19 58 , and that death occurred at 7:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Howard Goodman M.D.		ADDRESS (Street, city or town, state) The Clinical Center	
PHYSICIAN'S NAME (Type) Howard Goodman, M. D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-18-58	
22c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden		22d. LOCATION (City, town, or county) (State) Falls Church Va.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons 3501 14th St., N.W., Wash. 10		24a. REC'D BY REGISTRAR JUN 19 '58	
		24b. REGISTRAR'S SIGNATURE W. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

MASSACHUSETTS
DEPARTMENT OF HEALTH
BOSTON

Name of Deceased		Sex		Age		Date of Death	
Place of Birth		Usual Residence		Cause of Death		Occupation	
Manner of Death		Physician's Signature		Medical Examiner's Signature		Registrar's Signature	
Date of Burial		Place of Burial		Name of Burial Place		Name of Minister of the Gospel	
Name of Informant		Relationship to Deceased		Signature of Informant		Date of Statement	

7000

CERTIFICATE OF DEATH

06973

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>4816 MONTGOMERY LANE</u>			
3. NAME OF DECEASED (Type or print) First <u>FANNIE</u> Middle <u>H</u> Last <u>FIELD</u>				4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/1/89</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR: Months <u>10</u> Days <u>16</u> Hours <u></u> Min. <u></u>		11. AGE (In years last birthday) <u>70</u> yrs.		12. IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. W.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Charles H. Hockette</u>				14. MOTHER'S MAIDEN NAME <u>Sophie OLSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Frances H. O'Shaughnessy</u> Address <u>7 Teas #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral edema</u> DUE TO <u>626X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Toxemia</u> DUE TO (c) <u>Telvic peritonitis -</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arterionephrosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6-14</u> , 19 <u>58</u> , to <u>6-17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-17</u> , 19 <u>58</u> , and that death occurred at <u>1:50 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>1835 Eye St. N.W. Wash. D.C.</u>				DATE SIGNED <u>5/17/58</u>			
ACTUAL SIGNATURE <u>Walter Atkinson</u>				M.D. <u>1835 Eye St. N.W. Wash. D.C.</u>			
PHYSICIAN'S NAME (Type) <u>WALTER ATKINSON</u>				<u>1835 Eye St. N.W. Wash. D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>		22b. DATE THEREOF <u>6/20/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Kensico Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Kisco, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>JUN 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

7001 CERTIFICATE OF DEATH

06974

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>12 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. STREET ADDRESS <u>4 th Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Army</u> Middle <u>Fields</u> Last <u>Fields</u>				4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/14/93</u>	9. AGE (In years last birthday) <u>65</u> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Martinsburg, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Clayton S. Fields</u>				14. MOTHER'S MAIDEN NAME <u>Francis Wood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Harriet Long</u> Address <u>300 Rittenhouse Washington, D.C. ST. N.W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> DUE TO (c) <u>Cor pulmonale</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 week</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>6-1-1958</u> to <u>6-12-1958</u> , that I last saw the deceased alive on <u>6-11-1958</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							DATE SIGNED <u>6-17-58</u>
ACTUAL SIGNATURE <u>Jason Geiger</u> M.D.				ADDRESS (Street, city or town, state) <u>231 Pershing Drive Silver Spring, Md.</u>		DATE SIGNED <u>6-17-58</u>	
PHYSICIAN'S NAME (Type) <u>JASON GEIGER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/14/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		22d. LOCATION (City, town, or county) <u>Beallsville Md</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hillen, Barnesville, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE JUN 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. B. Hillen</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

...the ... of ...

7002

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 19 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Floyd Middle Grayston Last Fisher				4. DATE OF DEATH Month June Day 7 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1910		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mathematician		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Marvin Fisher				14. MOTHER'S MAIDEN NAME Ida Schlagel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic adenocarcinoma of prostate 200.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia familial thrombocytopenic purpura							INTERVAL BETWEEN ONSET AND DEATH 1 yr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 18 , 19 58 , to June 7 , 19 58 , that I last saw the deceased alive on June 7 , 19 58 , and that death occurred at 4:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Lawrence Schlachter M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 6-7-58			
PHYSICIAN'S NAME (Type) Lawrence Schlachter, M. D.				ADDRESS The National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF June 9, 1958		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Switzland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. P. Ives mpls.				ADDRESS 2847 Wilson Blvd Arlington, Va		24a. REC'D BY REGISTRAR DATE JUN 10 58	
				24b. REGISTRAR'S SIGNATURE W. L. Schuch			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7003

CERTIFICATE OF DEATH

Reg. Dist. No.

06976

1. PLACE OF DEATH o. COUNTY <i>MONTGOMERY</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>DC</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PENNSINGTON</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>WASHINGTON</i> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>PENNSINGTON GARDENS</i>				d. STREET ADDRESS <i>6433-8-ST. NW</i>			
3. NAME OF DECEASED (Type or print) <i>Julian S. Freeman</i>				4. DATE OF DEATH Month <i>6</i> Day <i>12</i> Year <i>1958</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 9, 1868</i> 89 yrs.	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Bakery</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>James M. Freeman</i>				14. MOTHER'S MAIDEN NAME <i>Mary Dent</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>JOELIAN D. FREEMAN</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute congestive heart failure</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arteriosclerotic heart disease</i> DUE TO (c) <i>generalized arteriosclerosis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i> <i>10 yrs</i> <i>20 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>June 12, 1958</i> to <i>June 12, 1958</i> , that I last saw the deceased alive on <i>June 12, 1958</i> , and that death occurred at <i>8:25 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>7852 16 NW Wash DC</i> <i>6/12/58</i> ACTUAL SIGNATURE <i>H. F. Kreuzburg</i> M.D. <i>7852 16 NW Wash DC</i> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Buried</i>		<i>6-14-58</i>		<i>Wood Creek</i>		<i>Washington D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. W. Lee Son</i>				ADDRESS <i>Wash D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 16 '58</i>	
				24b. REGISTRAR'S SIGNATURE <i>W. Lee</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 4 and 5 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7004

CERTIFICATE OF DEATH

Reg. Dist. No.

06977

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b ANNAPOLIS 0210.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARILEA NURSING HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) AMY ELIZABETH GAMBRILL				4. DATE OF DEATH JUNE 15 19 58			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 19, 1892	
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 8 Days 26		11. IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Allen, Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME John Murray				14. MOTHER'S MAIDEN NAME Mava Bounds			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 			
17. INFORMANT Mr. O. Howard Gambrill (Husband)				Address Academy Seafood, Annapolis, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis & rupture 332x DUE TO Fatigue Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Cerebral arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Nov. 1957 to June 15, 1958 , that I last saw the deceased alive on 6/1/58 , 19 58 , and that death occurred at 10:12 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) 809 VIERS MILL ROAD DATE SIGNED JUNE 15, 1958							
ACTUAL SIGNATURE Stephen N. Jones				M.D. 809 VIERS MILL ROAD			
PHYSICIAN'S NAME (Type) STEPHEN N. JONES				SILVER SPRING, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Jun. 18, 1958		Allen Cemetery		Allen, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND			
24a. REC'D BY REGISTRAR JUN 18 '58				24b. REGISTRAR'S SIGNATURE Al. Leach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7005

CERTIFICATE OF DEATH

06978

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 35 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				d. STREET ADDRESS 3305 Macomb Street, N.W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Robert Middle Lee Last GHORMLEY				4. DATE OF DEATH Month June Day 21 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 15 October 1883	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Retired		11. BIRTHPLACE (State or foreign country) Oregon	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME David O. GHORMLEY				14. MOTHER'S MAIDEN NAME Alice M. ERWIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW-1, WW-II			
17. INFORMANT (Son) Robert L. GHORMLEY Jr.				Address 5408 Christy Dr. Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Post operative Prostectomy and DUE TO (c) Removal of Bladder Carcinoma INTERVAL BETWEEN ONSET AND DEATH Sudden 2 wks. ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 17 May , 19 58 , to 21 June , 19 58 , that I last saw the deceased alive on 21 June , 19 58 , and that death occurred at 7:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 6-22-58							
ACTUAL SIGNATURE Melvin Rotner M.D.							
PHYSICIAN'S NAME (Type) MELVIN ROTNER, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-25-58		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's & Sons				ADDRESS Washington, D.C.		24a. REC'D BY REGISTRAR June 24 '58	
24b. REGISTRAR'S SIGNATURE Alfred Smith							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6944

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>5 hours 39 min</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u> d. STREET ADDRESS <u>2000 Oglethorpe Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Infant Girl Gladstone</u>		4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1958</u>
9. AGE (In years last birthday) yrs. <u>5</u> Months <u>39</u> Days <u>5</u> Min. <u>39</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Amos Gladstone</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Laura Simmons</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mother's chart</u>	
17. INFORMANT <u>Mother's chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity - 27 weeks gestation</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>6 hours</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 21, 1958</u> to <u>June 21, 1958</u> , that I last saw the deceased alive on <u>June 21, 1958</u> , and that death occurred at <u>4:22 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Sydney Leventhal</u> M.D. <u>9210 Colesville Rd., Silver Spring, Md.</u>		PHYSICIAN'S NAME (Type) <u>Sydney Leventhal, M.D., 9210 Colesville Road, Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>6-22-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wash. San. and Hosp.</u>		22d. LOCATION (City, town, or county) (State) <u>Takoma Park, Wash. 12, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare</u>		24. REC'D BY REGISTRAR DATE <u>JUN 26 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Robert A. Hare</u>		24c. REGISTRAR'S SIGNATURE <u>Robert A. Hare</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7006

CERTIFICATE OF DEATH

06980

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co. MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Vernon Godsey</u>				4. DATE OF DEATH Month Day Year <u>June 21 1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 2, 1883</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>11 19</u>		10. IF UNDER 24 HRS. <u>11 19</u>		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher-Retired</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William W. Godsey</u>				14. MOTHER'S MAIDEN NAME <u>? Wood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Mrs. India Godsey</u> Address <u>same as above</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis - Right</u> DUE TO <u>Hemiplegia followed by Left Hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Central arteriosclerosis</u> (c) <u>Central arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6/9/58</u> , 19 <u>58</u> , to <u>6/21/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/20/58</u> , 19 <u>58</u> and that death occurred at <u>5:30 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Frank</u> M.D.				ADDRESS (Street, city or town, state) <u>544 W. MONTGOMERY AVE</u> DATE SIGNED <u>6/21/58</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM FRANK, M.D.</u>				<u>ROCKVILLE, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur. transit</u>		22b. DATE THEREOF <u>6/22/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sivley Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Chattanooga, Tennessee</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>7557 Wis. Ave. Bethesda, Md</u>				24a. REC'D BY REGISTRAR <u>JUN 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4. may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3002

DECEASED NAME Robert A. Rumpsey-557 W. Ave. Bethesda, Md.		DATE OF BIRTH 11/23/1898		PLACE OF BIRTH Baltimore, Md.	
SEX Male		RACE White		OCCUPATION Unknown	
MARITAL STATUS Single		CAUSE OF DEATH Unknown		PLACE OF DEATH Baltimore, Md.	
DATE OF DEATH 11/23/1955		TIME OF DEATH 11:00 AM		PLACE OF DEATH Baltimore, Md.	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESS (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)		SIGNATURE OF JURY (None)	

3

This certificate is to be filled out by the physician or other person who has attended the deceased, or by the coroner or other person who has examined the body, or by the registrar or other person who has been authorized by the State Department of Health to fill out this certificate. It is to be filled out in duplicate, one copy to be retained by the State Department of Health, and the other copy to be retained by the local health department.

7007

CERTIFICATE OF DEATH

Reg. Dist. No. 215 m

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 5 mos. 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucy Middle Russell Last GOLDSBY		4. DATE OF DEATH Month June Day 13 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 March 1889
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR: Months 6 Days 13 Hours 19 Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursing		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy, Retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Russell		14. MOTHER'S MAIDEN NAME Lucy Herbert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 5-4-17 to 1-7-34		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Son, John R. Goldsby, 4519 Highland Ave.,		Address Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Cholera Pneumonia DUE TO (b) Chronic Coronary Heart Failure DUE TO (c) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 7 days 6 mos. unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 491X			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 January , 19 58 to 13 June , 19 58 , that I last saw the deceased alive on 13 June , 19 58 , and that death occurred at 8:40 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE R.A. Pumphrey		DATE SIGNED 6-13-58	
PHYSICIAN'S NAME (Type) T.S. DUNN, JR. LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-18-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		24a. REC'D BY REGISTRAR JUN 16 58	
ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24b. REGISTRAR'S SIGNATURE W. J. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1907

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	

7008

CERTIFICATE OF DEATH

Reg. Dist. No. 215

06982

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS 1213 1/2 "C" Street, N.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last GOODING		4. DATE OF DEATH Month June Day 4 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 June 1958
9. AGE (In years last birthday) yrs. 14		IF UNDER 1 YEAR Months Days 14 26	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Clarence Wilson GOODING		14. MOTHER'S MAIDEN NAME Virginia Lee RICHARDSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE (CONGENITAL ATELECTASIS) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PREMATURITY DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 June , 19 58 , to 4 June , 19 58 , that I last saw the deceased alive on 4 June , 19 58 , and that death occurred at 1:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 6-6-58			
ACTUAL SIGNATURE Daniel Shuptar		M.D. U.S. Naval Hospital, Bethesda, Md. 6-6-58	
PHYSICIAN'S NAME (Type) DANIEL SHUPTAR, LT MC USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-11-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey		24a. REC'D BY REGISTRAR JUN 10 '58	
ADDRESS 7557 Wisconsin Ave., Bethesda, Md		24b. REGISTRAR'S SIGNATURE Alfred Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6945

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington, D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital 2029 P St., N.W.</u>		d. STREET ADDRESS <u>2029 P St., N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frances Eleanor Goodwin</u>		4. DATE OF DEATH Month Day Year <u>June 3 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-1-81</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Steno</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Wilbur Goodwin</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Payne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Pt's chart</u>	
17. INFORMANT <u>Pt's chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>430.0</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (b) <u>Neurotizing renal papillitis</u> cause (c) <u>Bacterial endocarditis</u> lying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obstruction of Common Bileduct by calculi</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/13/58</u> to <u>6/3/58</u> , that I last saw the deceased alive on <u>6/3/58</u> , and that death occurred at <u>6:45</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Raymond O. West</u> M.D. <u>7600 Carroll Ave. Takoma Park, Md.</u>			
ACTUAL SIGNATURE <u>Raymond O. West</u>			
PHYSICIAN'S NAME (Type) <u>Raymond O. West</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>6/6/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Buchanan Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Buchanan, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.-2901 14th St., N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 6 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. Hedrick</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

DECEASED

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

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Certificate of Cause of Death
Investigation conducted by
Health Department
10 days

X

7009

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9301 Weaver Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) REINE AGNES GRAND				4. DATE OF DEATH Month JUNE Day 8 Year 1958			
5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/10/84	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Rochon				14. MOTHER'S MAIDEN NAME Marie Wagner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Mr. Joseph A. Grand, 310 Brewster Court				Address Silver Spring, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE Lymphocytic LEUKEMIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ONE MONTH DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1956 to June 8, 1958 , that I last saw the deceased alive on June 8, 1958 , and that death occurred at 7:00 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 5075 ABERDEEN RD Bethesda MD				DATE SIGNED 6/8/58			
ACTUAL SIGNATURE DEWITT E. DELAWTER				M.D. DEWITT E. DELAWTER, M.D.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/11/58		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR JUN 11 1958	
				24b. REGISTRAR'S SIGNATURE W. E. Delawter			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7010 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06985

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>			d. STREET ADDRESS <u>7904 Wisconsin Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Glennie</u> Middle <u>LUCILLE</u> Last <u>Gray</u>			4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-14-1884</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MONT. CO. MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>HENLEY</u>			
14. MOTHER'S MAIDEN NAME <u>MARGARET MULLICAN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NONE</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>ARLINGTON 5, VA.</u> <u>MR. NORMAN A. GRAY - 6249 N. WASH. BLVD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertention</u> (c) <u></u> DUE TO (a), stating the underlying cause lost. (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u>		20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6/19/58</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Suitland, Maryland</u>		22e. (State) <u></u>		22f. (Country) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUN 23 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Seuch</u>		24c. REGISTRAR'S NAME <u></u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG230 6-16-58 et
CERTIFICATE OF DEATH

7011

06986

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Derwood RFD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Derwood RFD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bowie Mill Rd</u>		d. STREET ADDRESS <u>Bowie Mill Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Franklin</u> Last <u>Gregg</u>		4. DATE OF DEATH Month <u>6</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/22/1896</u>
9. AGE (In years and birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William Elias Gregg</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Stream</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs C. F. Gregg, Derwood, Rt 1, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443x Congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Hypertensive Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wk</u> <u>Yes</u> <u>Yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemiplegia, right</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/7</u> 19 <u>58</u> to <u>6/7</u> 19 <u>58</u> , that I last saw the deceased alive on <u>6/7</u> 19 <u>58</u> , and that death occurred at <u>1:20 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>C. H. Ligon</u> M.D. <u>Sandy Spring Md</u> PHYSICIAN'S NAME (Type) <u>C. H. Ligon</u>			
22a. BURIAL, CREMATION, <u>Burial</u> (Specify)		22b. DATE THEREOF <u>June 9 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Burtonsville, Union</u>		22d. LOCATION (City, town, or county) (State) <u>Burtonsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W Barber</u> ADDRESS <u>Laytonsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 11 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Authentic</u>			

18 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7012

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 16 DC 47x-3</u> d. STREET ADDRESS <u>4426 Hawthorne St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Thomas Haines</u>			4. DATE OF DEATH Month Day Year <u>June 5 1958</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/8/1882</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Certified Public Acct.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			
13. FATHER'S NAME <u>Louis Haines</u>			14. MOTHER'S M maiden NAME <u>Letetia Beazley</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>C. Gordon Haines</u> Address <u>1240 Lake Falls Road Baltimore, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial damage</u> DUE TO (c) <u>Coronary Thrombosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>9 weeks</u> <u>4 weeks</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>5/3/58</u> , 19 <u>58</u> , to <u>6/5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/5</u> , 19 <u>58</u> , and that death occurred at <u>12:30</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4301 48th St NW, Wash DC</u> DATE SIGNED <u>6/5/58</u>							
ACTUAL SIGNATURE <u>[Signature]</u> PHYSICIAN'S NAME (Type) <u>Sherman A. Thomas</u>		ADDRESS <u>4301 48th St NW, Wash D.C.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/7/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. Hines Co</u> ADDRESS <u>2901-14th NW Washington D.C.</u>			24a. REC'D BY REGISTRAR DATE <u>JUN 9 '58</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1912

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1867		BALTIMORE		MD		USA	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT		COUNTRY OF INTERMENT	
OCT 10 1912		BALTIMORE		MD		USA		OCT 12 1912		BALTIMORE		MD		USA	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SPECIAL INSTRUCTIONS	
CORONARY THROMBOSIS		NATURAL		LABORER		HIGH SCHOOL		METHODIST		MARRIED		3			
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

100-11111-100
J. H. HARRIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7013

Item 1 File #230 6-12-58 et

CERTIFICATE OF DEATH

06988

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>BALBOA - C.Z.</u> b. COUNTY <u>89X-3</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Box 1639 BALBOA, C.Z.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Althaus Home Nursing Home</u> <u>9301 Weaver St.</u>			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) <u>Sarah</u> First <u>E</u> Middle <u>Ham</u> Last			4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1958</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-25-78</u>		9. AGE (In years last birthday) <u>79</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSE</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>COLORADO</u>
13. FATHER'S NAME <u>Fullerton, James</u>			14. MOTHER'S MAIDEN NAME <u>Trujillo, Feliciano</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Daughter -</u>			Address <u>SAME AS - ABOVE</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Neoplasm</u> <u>193.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. <u>9</u> p. m. Month, Day, Year <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>June 6th, 1958</u> to <u>June 7th, 1958</u> , that I last saw the deceased alive on <u>June 6th, 1958</u> , and that death occurred at <u>11:40 a.m.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Philip E. Jones</u> M.D.			ADDRESS (Street, city or town, state) <u>918 Ellsworth Drive</u>		
PHYSICIAN'S NAME (Type) <u>Philip E. Jones</u>			DATE SIGNED <u>Silver Spring, Md</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>		<u>JUNE 12, 1958</u>		<u>GREENWOOD MEMORIAL PARK</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
<u>Philip E. Jones</u>		<u>WASH, D.C.</u>		<u>254 CARROLL ST NW</u>	
24b. REGISTRAR'S SIGNATURE		24c. DATE		24d. REGISTRAR'S SIGNATURE	
<u>Al. Beach</u>		<u>JUN 10 '58</u>		<u>Al. Beach</u>	

CERTIFICATE OF DEATH

1913

Page One of Two

DECEASED'S NAME [Faint text]		SEX [Faint text]		AGE [Faint text]		DATE OF BIRTH [Faint text]		PLACE OF BIRTH [Faint text]		OCCUPATION [Faint text]	
MARITAL STATUS [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		DATE OF DEATH [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF CLERK [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF JUDGE [Faint text]	
CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]	

MASSACHUSETTS DEPARTMENT OF HEALTH - BURLINGAME, 18

6946

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 15-56-1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		d. STREET ADDRESS 12512 Denley Road	
3. NAME OF DECEASED (Type or print) Infant Girl Hankin		4. DATE OF DEATH Month June Day 28 Year 1958	
5. SEX Girl	6. COLOR OR RACE Jewish	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1958
9. AGE (In years last birthday) yrs. 3		10. IF UNDER 1 YEAR Months 3 Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Coleman Robert Hankin		14. MOTHER'S MAIDEN NAME Lois Lichtenstein	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mother's chart		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 762.5 IMMEDIATE CAUSE (a) X Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) X Congenital Atelectasis DUE TO X Passive Congestion, liver, spleen, brain			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 0 a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2046-28 , 19 58 , to 6-28-58 , that I lost s/he the deceased alive on 6/28 , 19 58 , and that death occurred at 7:44 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6-28-58 DATE SIGNED			
ACTUAL SIGNATURE Stanley I. Wolf M.D.			
PHYSICIAN'S NAME (Type) STANLEY I. WOLF, M.D. Wheaton, Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6-30-58	
22c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium and Hospital Takoma Park, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. Hare Wash. San. & Hosp.		24a. REC'D BY REGISTRAR DATE JUL 2 '58	
24b. REGISTRAR'S SIGNATURE W. H. Hare			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be obtained by the hospital or attending physician.

5) **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

DATE

REPORT MADE AT

REPORT MADE BY

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF BURIAL

NAME OF CREMATION

NAME OF URN

NAME OF CASK

NAME OF COFFIN

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06990

7014

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY,</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY,</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>6.4 YEARS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>168 FLEETWOOD TERRACE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRED</u> Middle <u>M.</u> Last <u>HART</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cartographic Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Orson Edbert Hart</u>		14. MOTHER'S MAIDEN NAME <u>Harriet E. Fitch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Rest Home Records - 168 Fleetwood Terrace Silver Spring, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMPHYSEMA AND FIBROSIS</u> <u>527.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>4 YEARS.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB.</u> , 19 <u>56</u> , to <u>JUNE 27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JUNE 27</u> , 19 <u>58</u> , and that death occurred at <u>1:45</u> A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>James A. Roberts</u> M.D. <u>8907 GEORGE AVENUE</u> <u>6/27/58</u> ACTUAL SIGNATURE NAME (Type) <u>JAMES A. ROBERTS</u> <u>SILVER SPRING, MARYLAND.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/30/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., -2901 14th St., N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 30 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Asst. Secy</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7015 CERTIFICATE OF DEATH

06991

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b D.O.A.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - St. Georges Post Office			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital				d. STREET ADDRESS St. Georges Island 18X-2			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-around;"> First Ronald Middle Lee Last HAYNES </div>				4. DATE OF DEATH <div style="display: flex; justify-content: space-around;"> Month June Day 10 Year 19 58 </div>					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 June 1958		9. AGE (In years lost birthday) yrs. <div style="display: flex; justify-content: space-around;"> IF UNDER 1 YEAR Months 13 IF UNDER 24 HRS. Days 10 Hours 58 Min 58 </div>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jack Lemon HAYNES					14. MOTHER'S MAIDEN NAME Patricia Annette MC CORMICK				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Address Father St. Georges Island, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyaline Membrane Disease 773.5 DUE TO <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u>lying cause last. </div> <div style="width: 45%;"> (b) Prematurity (c) </div> </div> </div>								INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year <div style="display: flex; justify-content: space-between;"> Hour o. m. 19 </div>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 10, 19 58 to June 10 19 58 that I last saw the deceased alive on June 10, 19 58 and that death occurred at 10 58 AM from the causes and on the date stated above. <div style="display: flex; justify-content: space-between;"> ADDRESS (Street, city or town, state) DATE SIGNED </div>									
ACTUAL SIGNATURE Irving B. KORETSKY			PHYSICIAN'S NAME (Type) LT MC USNR U.S. Naval Air Station, 6-10-58						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 6-13-58		22c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		22d. LOCATION (City, town, or county) (State) Great Mills, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Station Hospital, U.S. Naval Air Station, Patuxent River, Md.					24a. REC'D BY REGISTRAR JUN 16 58		24b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
 Dr. Frank J. Broschart, MD, Montgomery County Medical Examiner notified.
 U.S. Naval Hospital, Bethesda, Md. Instructed to handle in usual manner.

2051172 XV2

CERTIFICATE OF DEATH

7012

Form No. 10

DATE OF DEATH

PLACE

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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CAUSE OF DEATH

7016

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Argyle Club Rd., Layhill,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Seymour Nursing Home				d. STREET ADDRESS 1307 14th Street, N.W.			
3. NAME OF DECEASED (Type or print) First DOROTHEA Middle ROEDER Last HEITMULLER				4. DATE OF DEATH Month 6 Day 2 Year 1958			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/14/1866	
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Roeder				14. MOTHER'S MAIDEN NAME "Unobtainable"			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Stuart P. Heitmuller	
				Address Takoma Pk, Md.		804 Hudson Ave.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vascular Disease DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 1940 to June 2, 1958 , that I last saw the deceased alive on June 1, 1958 and that death occurred at 7:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5000 Reno Rd NW DATE SIGNED 6-2-58							
ACTUAL SIGNATURE Wm F Luckett M.D.							
PHYSICIAN'S NAME (Type) Wm. F. Luckett							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
burial		6/6/58		Glenwood Cemetery		Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W.				ADDRESS Wash, D.C.		24a. REC'D BY REGISTRAR DATE JUN 5 '58	
				24b. REGISTRAR'S SIGNATURE Albert Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7016

File No. 10

Name of Deceased		Age		Sex		Race		Date of Death	
George W. Jackson		35		Male		White		1922	
Place of Birth		Date of Birth		Cause of Death		Disease		Occupation	
Baltimore, Md.		1887		Heart Disease		Myocardial Infarction		None	
Residence at Time of Death		Date of Death		Time of Death		Place of Death		Signature of Physician	
1307 1/2 Street, N.W.		1922		10:00 AM		Home		J. F. Jackson	
Signature of Informant		Relationship to Deceased		Signature of Registrar		Signature of Medical Officer		Signature of Health Officer	
J. F. Jackson		Son		J. F. Jackson		J. F. Jackson		J. F. Jackson	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06993

7017

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4605 Maple Avenue</u>				d. STREET ADDRESS <u>4605 Maple Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS ALVIN HERRING</u>				4. DATE OF DEATH Month Day Year <u>June 2 19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 5, 1875</u>		9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days <u>5 27</u>	IF UNDER 24 HRS. Hours Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor, ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov't</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes Spanish Am.</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Nancy L. Herring</u>		Address <u>same as # 2d</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertension</u> (a), stating the underlying cause lost. (c) <u> </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u> </u> years	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Frank J. Broschart, MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<u>6/2/58</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u> </u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>		DATE <u>JUN 4 '58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE BAR OF
INDIANA

7018

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 2yr.1mo.27days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Arlington			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 4513 20th Street			
3. NAME OF DECEASED (Type or print) First Charles Middle Joseph Last HOLEMAN				4. DATE OF DEATH Month June Day 21 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 14 March 1880	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Retired			
11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME William HOLEMAN				14. MOTHER'S MAIDEN NAME Hannah SHEPHERD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW-I			
17. INFORMANT (Wife) Mrs. Pricilla M. HOLEMAN (Same As #2)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO Cerebrovascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) unk							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331x INTERVAL BETWEEN ONSET AND DEATH 3 days 6 mos unk							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 24 April , 19 56 , to 21 June , 19 58 , that I last saw the deceased alive on 21 June , 19 58 , and that death occurred at 9:30A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE T.S. DUNN, JR. M.D. U.S. Naval Hospital, Bethesda, Md. 6-21-58							
PHYSICIAN'S NAME (Type) T.S. DUNN, JR. LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6-25-58			
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery				22d. LOCATION (City, town, or county) (State) Arlington, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE B. M. Pumphrey				24a. REC'D BY REGISTRAR June 24 '58			
24b. REGISTRAR'S SIGNATURE Rede...							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7019

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> d. STREET ADDRESS <u>3604 Shepherd Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ella</u> First <u>M.</u> Middle <u>HOLLAND</u> Last				4. DATE OF DEATH <u>June 25,</u> Month <u>19 58</u> Day <u>19</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/11/73</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>85</u> Days <u>85</u> Hours <u>85</u> Min. <u>85</u>		IF UNDER 24 HRS. Months <u>85</u> Days <u>85</u> Hours <u>85</u> Min. <u>85</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Edmund Martin</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Mr. James C. Holland</u>		17. INFORMANT Address <u>Son Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO <u>1</u> (c) <u>1</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>58</u> , to <u>June</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 25</u> , 19 <u>58</u> , and that death occurred at <u>2:40</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leo Donovan</u>				M.D. <u>8016 Georgetown Rd</u>			
PHYSICIAN'S NAME (Type) <u>Leo Donovan</u>				ADDRESS (Street, city or town, state) <u>8016 Georgetown Rd, Bethesda, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumfrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUN 27 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Albert</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

1918

Place of Birth

Married

John J. Jones

John J. Jones

John J. Jones

Place of Birth

John J. Jones

John J. Jones

John J. Jones

John J. Jones

John J. Jones

John J. Jones

John J. Jones

John J. Jones

John J. Jones

John J. Jones

John J. Jones

John J. Jones

John J. Jones

John J. Jones

John J. Jones

John J. Jones

John J. Jones

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7020

CERTIFICATE OF DEATH

06996

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 2 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MAPLE LANE NURSING HOME				d. STREET ADDRESS 9810 GEORGIA AVENUE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First SARAH Middle B. Last HOLLAND				4. DATE OF DEATH Month JUNE Day 19 Year 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/18/1874	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME DAVID S. HOLLAND				14. MOTHER'S MAIDEN NAME MARY E. HUTTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT T. STANLEY HOLLAND, SOMERSET, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE HEART DISEASE 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) ESSENTIAL HYPERTENSION				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 0. 11. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from JUNE 29, 1956 , to JUNE 19, 1958 , that I last saw the deceased alive on JUNE 19, 1958 , and that death occurred at 8:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE HENRY M. LOWDEN				ADDRESS (Street, city or town, state) DATE SIGNED 5206 NORWAY DR. 6/19/58			
PHYSICIAN'S NAME (Type) HENRY M. LOWDEN				CHEVY CHASE, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/21/58		22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Lawlor's Son 1356 R. One Wash. D.C.				24a. REC'D BY REGISTRAR JUN 23 58		24b. REGISTRAR'S SIGNATURE W. E. ...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1930

NAME OF DECEASED JAMES H. HARRIS		DATE OF DEATH 12/15/30	
AGE 65		SEX Male	
PLACE OF BIRTH Maryland		DATE OF BIRTH 11/10/65	
OCCUPATION Farmer		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		PLACE OF DEATH Home	
SIGNATURE OF PHYSICIAN J. H. Harris		SIGNATURE OF WITNESSES J. H. Harris	
DATE 12/15/30		TIME 10:00 AM	
LOCALITY Baltimore		COUNTY Baltimore	
STATE Maryland		FEDERAL BUREAU OF INVESTIGATION U.S. DEPARTMENT OF JUSTICE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7021

CERTIFICATE OF DEATH

Reg. Dist. No.

06997

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 1.2.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 Month 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 110 Market Street			
3. NAME OF DECEASED (Type or print) First Hiester Middle (n) Last HOOGEWERFF				4. DATE OF DEATH Month June Day 8 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-19-92	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min.		IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) District of Columbia	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME John Adriaan HOOGEWERFF				14. MOTHER'S MAIDEN NAME Edwardine HIESTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes Class 1912 WWII		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Mary-Safford HOOGEWERFF (Same as #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH Undetermined	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 5-8- , 19 58 , to 6-8- , 19 58 , that I last saw the deceased alive on 6-8- , 19 58 , and that death occurred at 6:40A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE F. S. Caldwell				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 6-9-58			
PHYSICIAN'S NAME (Type) F. S. CALDWELL, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-11-58		22c. NAME OF CEMETERY OR CREMATORY Naval Academy Cemetary		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John M. TAYLOR				ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR JUN 10 '58	
				24b. REGISTRAR'S SIGNATURE W. L. Search			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7025

U.S. GOVERNMENT PRINTING OFFICE: 1964 O - 350-110-2

MADE IN U.S.A.

1. Name of deceased (Print or type full name) <i>John Doe</i>	
2. Sex <i>Male</i>	
3. Date of birth (Month, day, year) <i>Jan 15 1925</i>	
4. Place of birth (City, State, Country) <i>Baltimore, Maryland, U.S.A.</i>	
5. Race <i>White</i>	
6. Occupation (If any) <i>None</i>	
7. Usual residence (Street, City, State, Country) <i>123 Main St, Baltimore, Md.</i>	
8. Date of death (Month, day, year) <i>Dec 10 1985</i>	
9. Place of death (City, State, Country) <i>Baltimore, Maryland, U.S.A.</i>	
10. Cause of death (List all causes, beginning with immediate cause) <i>Heart Disease</i>	
11. Manner of death (Natural, Accident, Suicide, Homicide) <i>Natural</i>	
12. Signature of physician (Print name and sign) <i>John Doe</i>	
13. Signature of registrar (Print name and sign) <i>John Doe</i>	
14. Date of registration (Month, day, year) <i>Dec 10 1985</i>	
15. Registrar's office (City, State, Country) <i>Baltimore, Maryland, U.S.A.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06998

6947

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>1-5-58 to 6-26-58</u> x <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>2909 Daniel Road</u>	
3. NAME OF DECEASED (Type or print) <u>Gertrude Chadsey Houston</u>		4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-4-71</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>Amer.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Sam Houston</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Waidley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Hospital Record</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Mammary Carcinoma</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> to <u>June 26</u> , 19 <u>58</u> that I last saw the deceased alive on <u>June 25</u> , 19 <u>58</u> , and that death occurred at <u>4:20 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) _____ DATE SIGNED _____	
ACTUAL SIGNATURE <u>Harry N. Carlton</u> M.D.		1816 R Street, N.W. <u>June 26, 1958</u>	
PHYSICIAN'S NAME (Type) <u>Harry N. Carlton</u>		1816 R Street, N.W.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6/28/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		23a. ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>	
23b. DATE <u>June 30 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Albert Lewis</u>	

CERTIFICATE OF DEATH

1937

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is oriented horizontally but contains vertical text labels for various fields.

NAME: _____

DATE: _____

TIME: _____

PLACE: _____

CAUSE: _____

SIGNATURE: _____

Other fields include checkboxes for "Stillborn" and "Fetal Death", and a section for "Medical History".

RECEIVED BY THE HEALTH DEPARTMENT OF BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7022

CERTIFICATE OF DEATH

06999

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY IN 1b 49hrs 48min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Beallsville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sharon Middle Kay Last Howard				4. DATE OF DEATH Month June Day 8 Year 1958			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 6, 1958	
9. AGE (In years lost birthday) yrs. 2		10. IF UNDER 1 YEAR Months 2		11. IF UNDER 24 HRS. Days 1 Hours 48			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none (baby)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? United states							
13. FATHER'S NAME Edward Howard				14. MOTHER'S MAIDEN NAME Catherine Howard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Catherine Howard Beallsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 769.5 DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Minimal Toxemia DUE TO (c) Minimal Toxemia							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/6, 1958 , to 6/8, 1958 , that I last saw the deceased alive on 6/7, 1958 , and that death occurred at 7:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE [Signature] M.D.				DATE SIGNED			
PHYSICIAN'S NAME (Type) Dr. Charles H. Ligon				Sandy Spring, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/10/58		22c. NAME OF CEMETERY OR CREMATORY Boyle Presbyterian		22d. LOCATION (City, town, or county) (State) Boyle Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Helton				ADDRESS Barnesville Md.		24a. REC'D BY REGISTRAR [Signature] DATE JUN 11 '58	
				24b. REGISTRAR'S SIGNATURE [Signature]			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07000

7023

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>1816 BRISBANE ST.</u>	
3. NAME OF DECEASED (Type or print) <u>BORNARD ELTON HYNSON</u>		4. DATE OF DEATH <u>JUNE 30 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 31, 1905</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER-contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own business</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GLENN HYNSON</u>		14. MOTHER'S MAIDEN NAME <u>Laura Bell Lampkin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-12-7649</u>	
17. INFORMANT <u>DOROTHY HYNSON</u>		Address <u>1816 BRISBANE ST. #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subendocardial + Posterior Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY INSUFFICIENCY</u> DUE TO (c) <u>CORONARY ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/14/58</u> , 19 <u>58</u> , to <u>6/30/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/30/58</u> , 19 <u>58</u> , and that death occurred at <u>6:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William D. Aud</u>		ADDRESS (Street, city or town, state) <u>906 Wilesville Rd Silver Spring Md</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM D. AUD</u>		DATE SIGNED <u>7/1/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/3/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. MEM. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>JUL 1 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Humphrey</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4. may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased: JOHN A. SMITH

2. Sex: Male

3. Age: 45

4. Date of Birth: 1910-03-15

5. Date of Death: 1955-08-10

6. Place of Birth: NEW YORK, N.Y.

7. Usual Residence: 1234 MAIN ST., BALTIMORE, MD.

8. Cause of Death: HEART DISEASE

9. Manner of Death: NATURAL

10. Physician: DR. J. H. BROWN

11. Burial Place: GREENWOOD CEMETERY

12. Signature of Physician: [Signature]

13. Signature of Registrar: [Signature]

14. Date of Registration: 1955-08-15

15. Registrar's Office: BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7024

CERTIFICATE OF DEATH

Reg. Dist. No.

07001

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Wesley Last Imes		4. DATE OF DEATH Month June Day 9 Year 1958	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jack Imes		14. MOTHER'S MAIDEN NAME Elizabeth Murphy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Emma Imes		226 N. Washington St., Rockville, Md.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident DUE TO Hypertensive Arteriosclerotic Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 20 hours 10 years
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 1958 , to 9 June 1958 , that I last saw the deceased alive on 9 June 1958 , and that death occurred at 3:45 P.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE John M. Smith	DATE SIGNED 12 June 58
ADDRESS (Street, city or town, state) Boyd, Md.	
PHYSICIAN'S NAME (Type) Robert L. Sawden	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/13/58	22c. NAME OF CEMETERY OR CREMATORY Martinsburg, Md.	22d. LOCATION (City, town, or county) (State) Martinsburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sawden		24a. REC'D BY REGISTRAR JUN 16 '58	24b. REGISTRAR'S SIGNATURE Robert L. Sawden

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7025 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07002

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>12 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8225 Custer Rd</u>				d. STREET ADDRESS <u>8225 Custer Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Reavis Jarboe</u>				4. DATE OF DEATH <u>June 24 1958</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-11-1920</u>		9. AGE (In years last birthday) <u>37</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Thomas H Reavis</u>				14. MOTHER'S MAIDEN NAME <u>Rita Bourgeois</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Thomas H Reavis</u> Address <u>3505- Ireland St Chevy Chase md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>shot gun wound in rt neck</u> DUE TO (c) _____</p> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted shot gun wound</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>7 p.m. 6/24 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Bethesda</u> (County) <u>Montg</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/27/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) <u>Rockville, Maryland</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>JUN 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR
DEATH

RECEIVED
BOSTON

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Age: _____

3. Sex: _____

4. Race: _____

5. Date of Birth: _____

6. Date of Death: _____

7. Place of Death: _____

8. Cause of Death: _____

9. Manner of Death: _____

10. Signature of Medical Examiner: _____

11. Signature of Coroner: _____

12. Signature of Registrar: _____

7026

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 73 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 1447 Cedar Street, S. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Edward Jeter		4. DATE OF DEATH Month Day Year June 26th, 19 58		5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 22, 1903		9. AGE (In years last birthday) 55 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dry Cleaner		10b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Fair Jeter		14. MOTHER'S MAIDEN NAME Beulah Hampton		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute lymphatic leukemia 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lymphosarcoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Septicemia, Staphylococcus aureus and E. coli.		INTERVAL BETWEEN ONSET AND DEATH 2 months 4 years		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 11th, 1958 , to June 26th, 1958 , that I last saw the deceased alive on June 26th, 1958 , and that death occurred at 8:00 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 6/26/58		ACTUAL SIGNATURE Kurt W. Kohn		M.D. The National Institutes of Health		PHYSICIAN'S NAME (Type) Bethesda 14, Maryland			
22a. BURIAL, CREMATION, or REMOVAL (Specify) 7/1/58		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Md.		23. FUNERAL DIRECTOR'S SIGNATURE W. Ernest Jarvis Co.		ADDRESS 432 You St. NW		24a. REC'D BY REGISTRAR DATE JUL 2 '58	
24b. REGISTRAR'S SIGNATURE Alfred													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7027 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07004

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>	c. LENGTH OF STAY IN 1b <u>1 hr. 20 min.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montg. Co. General</u>		d. STREET ADDRESS <u>Seven Locks Rd. RD# 2</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Mary A Johnson</u>		4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 14, 1894</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>24</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Edward Schwartzbeck</u>	
14. MOTHER'S MAIDEN NAME <u>Jane Kelly</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Cardiac Disease</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Diabetes Mellitus</u> (a), stating the underlying cause last. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____		20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____		(County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>June 8, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/11/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>JUN 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS
COUNTY OF DALLAS

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7028

CERTIFICATE OF DEATH

Reg. Dist. No.

07005

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Iowa</u> b. COUNTY <u>Green</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jefferson</u> 53x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>610 Locust St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mildred Leone Johnson</u>				4. DATE OF DEATH Month Day Year <u>June 27 19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/20/97</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>George Carley</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Grable</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>1</u>		17. INFORMANT <u>Martha L. Lockwood</u> Address <u>505 Fletcher Rd. Rockville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, post wall left ventricle</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary sclerosis, severe</u> years DUE TO (c) <u>Atherosclerosis, widespread, severe</u> years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral thrombosis & hemiplegia</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6/25</u> , 19 <u>58</u> , to <u>6/27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/27</u> , 19 <u>58</u> , and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. C. Maganzini</u> M.D.				ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd. Rockville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>H. C. Maganzini</u>				DATE SIGNED <u>6/28/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		22b. DATE THEREOF <u>7/2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HILLSIDE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MINNEAPOLIS, MINNESOTA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Humphrey</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1028

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. AGE [REDACTED]</p>	
<p>4. DATE OF BIRTH [REDACTED]</p>		<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. OCCUPATION [REDACTED]</p>	
<p>7. MARITAL STATUS [REDACTED]</p>		<p>8. DATE OF DEATH [REDACTED]</p>		<p>9. PLACE OF DEATH [REDACTED]</p>	
<p>10. CAUSE OF DEATH [REDACTED]</p>		<p>11. MEDICAL HISTORY [REDACTED]</p>		<p>12. HISTORY OF PRESENT ILLNESS [REDACTED]</p>	
<p>13. SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>14. SIGNATURE OF REGISTRAR [REDACTED]</p>		<p>15. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>16. NAME OF PHYSICIAN [REDACTED]</p>		<p>17. NAME OF REGISTRAR [REDACTED]</p>		<p>18. NAME OF WITNESS [REDACTED]</p>	
<p>19. ADDRESS OF DECEASED [REDACTED]</p>		<p>20. ADDRESS OF PHYSICIAN [REDACTED]</p>		<p>21. ADDRESS OF REGISTRAR [REDACTED]</p>	
<p>22. ADDRESS OF WITNESS [REDACTED]</p>		<p>23. ADDRESS OF DECEASED [REDACTED]</p>		<p>24. ADDRESS OF PHYSICIAN [REDACTED]</p>	
<p>25. ADDRESS OF REGISTRAR [REDACTED]</p>		<p>26. ADDRESS OF WITNESS [REDACTED]</p>		<p>27. ADDRESS OF DECEASED [REDACTED]</p>	
<p>28. ADDRESS OF PHYSICIAN [REDACTED]</p>		<p>29. ADDRESS OF REGISTRAR [REDACTED]</p>		<p>30. ADDRESS OF WITNESS [REDACTED]</p>	
<p>31. ADDRESS OF DECEASED [REDACTED]</p>		<p>32. ADDRESS OF PHYSICIAN [REDACTED]</p>		<p>33. ADDRESS OF REGISTRAR [REDACTED]</p>	
<p>34. ADDRESS OF WITNESS [REDACTED]</p>		<p>35. ADDRESS OF DECEASED [REDACTED]</p>		<p>36. ADDRESS OF PHYSICIAN [REDACTED]</p>	
<p>37. ADDRESS OF REGISTRAR [REDACTED]</p>		<p>38. ADDRESS OF WITNESS [REDACTED]</p>		<p>39. ADDRESS OF DECEASED [REDACTED]</p>	
<p>40. ADDRESS OF PHYSICIAN [REDACTED]</p>		<p>41. ADDRESS OF REGISTRAR [REDACTED]</p>		<p>42. ADDRESS OF WITNESS [REDACTED]</p>	
<p>43. ADDRESS OF DECEASED [REDACTED]</p>		<p>44. ADDRESS OF PHYSICIAN [REDACTED]</p>		<p>45. ADDRESS OF REGISTRAR [REDACTED]</p>	
<p>46. ADDRESS OF WITNESS [REDACTED]</p>		<p>47. ADDRESS OF DECEASED [REDACTED]</p>		<p>48. ADDRESS OF PHYSICIAN [REDACTED]</p>	
<p>49. ADDRESS OF REGISTRAR [REDACTED]</p>		<p>50. ADDRESS OF WITNESS [REDACTED]</p>		<p>51. ADDRESS OF DECEASED [REDACTED]</p>	
<p>52. ADDRESS OF PHYSICIAN [REDACTED]</p>		<p>53. ADDRESS OF REGISTRAR [REDACTED]</p>		<p>54. ADDRESS OF WITNESS [REDACTED]</p>	
<p>55. ADDRESS OF DECEASED [REDACTED]</p>		<p>56. ADDRESS OF PHYSICIAN [REDACTED]</p>		<p>57. ADDRESS OF REGISTRAR [REDACTED]</p>	
<p>58. ADDRESS OF WITNESS [REDACTED]</p>		<p>59. ADDRESS OF DECEASED [REDACTED]</p>		<p>60. ADDRESS OF PHYSICIAN [REDACTED]</p>	
<p>61. ADDRESS OF REGISTRAR [REDACTED]</p>		<p>62. ADDRESS OF WITNESS [REDACTED]</p>		<p>63. ADDRESS OF DECEASED [REDACTED]</p>	
<p>64. ADDRESS OF PHYSICIAN [REDACTED]</p>		<p>65. ADDRESS OF REGISTRAR [REDACTED]</p>		<p>66. ADDRESS OF WITNESS [REDACTED]</p>	
<p>67. ADDRESS OF DECEASED [REDACTED]</p>		<p>68. ADDRESS OF PHYSICIAN [REDACTED]</p>		<p>69. ADDRESS OF REGISTRAR [REDACTED]</p>	
<p>70. ADDRESS OF WITNESS [REDACTED]</p>		<p>71. ADDRESS OF DECEASED [REDACTED]</p>		<p>72. ADDRESS OF PHYSICIAN [REDACTED]</p>	
<p>73. ADDRESS OF REGISTRAR [REDACTED]</p>		<p>74. ADDRESS OF WITNESS [REDACTED]</p>		<p>75. ADDRESS OF DECEASED [REDACTED]</p>	
<p>76. ADDRESS OF PHYSICIAN [REDACTED]</p>		<p>77. ADDRESS OF REGISTRAR [REDACTED]</p>		<p>78. ADDRESS OF WITNESS [REDACTED]</p>	
<p>79. ADDRESS OF DECEASED [REDACTED]</p>		<p>80. ADDRESS OF PHYSICIAN [REDACTED]</p>		<p>81. ADDRESS OF REGISTRAR [REDACTED]</p>	
<p>82. ADDRESS OF WITNESS [REDACTED]</p>		<p>83. ADDRESS OF DECEASED [REDACTED]</p>		<p>84. ADDRESS OF PHYSICIAN [REDACTED]</p>	
<p>85. ADDRESS OF REGISTRAR [REDACTED]</p>		<p>86. ADDRESS OF WITNESS [REDACTED]</p>		<p>87. ADDRESS OF DECEASED [REDACTED]</p>	
<p>88. ADDRESS OF PHYSICIAN [REDACTED]</p>		<p>89. ADDRESS OF REGISTRAR [REDACTED]</p>		<p>90. ADDRESS OF WITNESS [REDACTED]</p>	
<p>91. ADDRESS OF DECEASED [REDACTED]</p>		<p>92. ADDRESS OF PHYSICIAN [REDACTED]</p>		<p>93. ADDRESS OF REGISTRAR [REDACTED]</p>	
<p>94. ADDRESS OF WITNESS [REDACTED]</p>		<p>95. ADDRESS OF DECEASED [REDACTED]</p>		<p>96. ADDRESS OF PHYSICIAN [REDACTED]</p>	
<p>97. ADDRESS OF REGISTRAR [REDACTED]</p>		<p>98. ADDRESS OF WITNESS [REDACTED]</p>		<p>99. ADDRESS OF DECEASED [REDACTED]</p>	
<p>100. ADDRESS OF PHYSICIAN [REDACTED]</p>		<p>101. ADDRESS OF REGISTRAR [REDACTED]</p>		<p>102. ADDRESS OF WITNESS [REDACTED]</p>	

RECEIVED
 BALTIMORE, MARYLAND
 DEPARTMENT OF HEALTH
 1028

7029

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 115 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Miller 62X-3			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Artie Middle Watson Last JONES				4. DATE OF DEATH Month June Day 19 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 May 1926		9. AGE (In years last birthday) 32 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Retired		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Watson JONES				14. MOTHER'S MAIDEN NAME Bertha Jewel CATLETT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1945 to 1-1-54		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Official Navy Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anaplastic Carcinoma with metastasis 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 8 Months.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 24 February, 1958 , to 19 June, 1958 , that I last saw the deceased alive on 19 June, 1958 , and that death occurred at 9:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edwin M. Hemness M.D.				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 6-20-58			
PHYSICIAN'S NAME (Type) Edwin M. Hemness, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-25-58		22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery		22d. LOCATION (City, town, or county) (State) Miller, Missouri	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS 1557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR JUN 24 '58	
				24b. REGISTRAR'S SIGNATURE Alfred			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6948

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY <u>Washington D.C.</u> 47X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Pk.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Jan. & Hosp.</u>				d. STREET ADDRESS <u>1305 Hamilton St. N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth Fraser Jones</u>				4. DATE OF DEATH <u>6</u> Month <u>13</u> Day <u>19</u> Year <u>58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-3-87</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Minnesota</u>		11. BIRTHPLACE (State or foreign country) <u>Amer.</u>	
13. FATHER'S NAME <u>John Cameron</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Bell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Patent's Chart (HOSPITAL RECORD)</u>		17. INFORMATION <u>Address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Abdominal Carcinoma</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>c. ascites</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>57</u> , to <u>6-13-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-13-</u> , 19 <u>58</u> , and that death occurred at <u>12:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul V. Starr</u> M.D.				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave. Takoma Park, Md.</u>			
DATE SIGNED <u>6-13-58</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>June 17, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	
22d. LOCATION (City, town, or county) <u>Bladensburg Md.</u>				(State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deaf Funeral Home</u>				ADDRESS <u>4812 Georgia Ave N.W.</u>		24a. REC'D BY REGISTRAR <u>June 18 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Paul V. Starr</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

7030

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. LENGTH OF STAY IN 1b 3 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 22 MANCHESTER PLACE				d. STREET ADDRESS 22 MANCHESTER PLACE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle J. Last KELLY				4. DATE OF DEATH Month 6 Day 12 Year 19 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 24, 1885	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME HIGH KELLY				14. MOTHER'S MAIDEN NAME WINIFRED -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578-24-8972		17. INFORMANT Address Sil. Sp. Md. Mrs. Doris M. Kelly 22 Manchester Pl			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic pulmonary emphysema 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 5 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 12, 1958 , to June 12, 1958 , that I last saw the deceased alive on June 11, 1958 , and that death occurred at 1245 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Bennet A. Porter Jr., M.D.				ADDRESS (Street, city or town, state) 9301 Colesville Rd., Silver Spring, Md.			
PHYSICIAN'S NAME (Type) Bennet A. Porter Jr., M.D.				DATE SIGNED June 12, 58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-14-58		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. J. Collins				ADDRESS Wash. D.C.		24a. REC'D BY REGISTRAR DATE JUN 13 '58	
FRANCIS J. COLLINS 3821 14th. St. N.W.				24b. REGISTRAR'S SIGNATURE W. J. ...			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

6949

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash., D.C.</u> b. COUNTY <u>47X-3</u>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>		d. STREET ADDRESS <u>314 Buchanan St., NW.</u>	
3. NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>Alberta</u> Last <u>Kennedy</u>		4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 3, 1883</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Jacob M. Assemer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Etta Marlow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Pat's Sister</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Broncho pneumonia</u> <u>443X</u> DUE TO <u>Cerebrovascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerotic C.V. Disease & Hypertension</u> (c) <u>?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>9 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 2, 1958</u> , to <u>June 4, 1958</u> , that I last saw the deceased alive on <u>6-11-58</u> , and that death occurred at <u>5 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6727-16th St. N.W.</u> DATE SIGNED <u>6-11-58</u>			
ACTUAL SIGNATURE <u>Taul Kanet</u>		PHYSICIAN'S NAME (Type) <u>TAUL KANET, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6/14/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		24a. REC'D BY REGISTRAR <u>2901-14th St. N.W.</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>		DATE <u>JUN 13 '58</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

1-1-38

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Race: *White*

4. Date of birth: *Jan 1, 1900*

5. Place of birth: *Baltimore, Md.*

6. Usual residence: *123 Main St., Baltimore, Md.*

7. Cause of death: *Heart Disease*

8. Date of death: *Dec 15, 1937*

9. Place of death: *Home*

10. Signature of physician: *J. H. Smith*

11. Signature of registrar: *W. B. Jones*

12. Signature of informant: *M. Doe*

13. Name of informant: *M. Doe*

14. Address of informant: *123 Main St., Baltimore, Md.*

15. Signature of informant: *M. Doe*

16. Date of completion: *Dec 16, 1937*

17. Registrar's office: *Baltimore, Md.*

18. Registrar's signature: *W. B. Jones*

19. Registrar's date: *Dec 16, 1937*

20. Registrar's stamp: *RECEIVED*

21. Registrar's initials: *W. B. J.*

22. Registrar's phone: *1234*

23. Registrar's fax: *5678*

24. Registrar's telex: *9012*

25. Registrar's telegram: *3456*

26. Registrar's cable: *7890*

27. Registrar's radio: *1122*

28. Registrar's mail: *3344*

29. Registrar's express: *5566*

30. Registrar's freight: *7788*

31. Registrar's passenger: *9900*

32. Registrar's other: *1122*

7031

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Homer</u> Last <u>Kilby</u>				4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 2, 1901</u>	
9. AGE (In years lost birthday) yrs. <u>56</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Division Director</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William H. Kilby</u>				14. MOTHER'S MAIDEN NAME <u>Anna B. VanDeCar</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>134-07-7419</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary prolapse</u> DUE TO <u>Metastatic brain disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Anaplastic carcinoma of bladder</u> DUE TO (c) <u>Interval between onset and death</u> <u>3 mcs</u> <u>3 weeks</u> <u>8 mcs</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>June 23</u> , 19 <u>58</u> , to <u>June 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 24</u> , 19 <u>58</u> , and that death occurred at <u>1:10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lawrence Schlachter</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Lawrence Schlachter, M. D.</u>				DATE SIGNED <u>6/24/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/26/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Calvary Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Fairfax County Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Shulman, Inc.</u>				ADDRESS <u>1756 Pa. Ave., N.W. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 27 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Schuch</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1-10-19

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
DATE OF BIRTH [Faint text, possibly "10-15-1900"]		PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]	
DATE OF DEATH [Faint text, possibly "11-1-1919"]		PLACE OF DEATH [Faint text, possibly "Home"]		CAUSE OF DEATH [Faint text, possibly "Pneumonia"]	
TIME OF DEATH [Faint text, possibly "10:30 AM"]		MANNER OF DEATH [Faint text, possibly "Natural"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "J. H. Smith"]	
SIGNATURE OF REGISTRAR [Faint text, possibly "A. B. Jones"]		SIGNATURE OF WITNESS [Faint text, possibly "C. D. Brown"]		SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]	
COUNTY [Faint text, possibly "Baltimore"]		CITY [Faint text, possibly "Baltimore"]		STATE [Faint text, possibly "Maryland"]	

7032

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 123 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 3229 Aberfoyle Place, N.W.			
3. NAME OF DECEASED (Type or print) First Posey Middle Thornton Last Kime				4. DATE OF DEATH Month June Day 8 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6 August 1895	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 10 Days 2		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer				10b. KIND OF BUSINESS OR INDUSTRY Legal Profession		11. BIRTHPLACE (State or foreign country) Indiana	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John T. Kime				14. MOTHER'S MAIDEN NAME Effa Posey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia & Pyelonephritis 292.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pseudomonas Septicemia DUE TO (c) Agonemic Pancreatitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Agonemic Pancreatitis							
INTERVAL BETWEEN ONSET AND DEATH 5 days							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from February 3, 1958 to June 8, 1958 , that I last saw the deceased alive on June 8, 1958 , and that death occurred at 8:44 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Habeeb Bacchus M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
DATE SIGNED 6-8-58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit				22b. DATE THEREOF 6/10/58		22c. NAME OF CEMETERY OR CREMATORY Walnut Hills Cemetery	
22d. LOCATION (City, town, or county) Petersburg, Indiana				22e. (State) Indiana			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE Alfred Smith				24c. (City or town)		24d. (County)	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pay the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7033

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b 19 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Indiana b. COUNTY Elkhart c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52X-3 d. STREET ADDRESS Route 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Benjamin Franklin Kindig				4. DATE OF DEATH Month Day Year June 9, 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 2, 1882 9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR: Months 9 Days 7 IF UNDER 24 HRS.: Hours 9 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurseryman		10b. KIND OF BUSINESS OR INDUSTRY Horticulture		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME David S. Kindig				14. MOTHER'S MAIDEN NAME Rebecca Shively			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 309-38-7670 Unavailable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) CEREBRAL HEMORRHAGE DUE TO (c) ACUTE LYMPHOCYTIC LEUKEMIA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from May 21 , 19 58 , to June 9 , 19 58 , that I last saw the deceased alive on June 9 , 19 58 , and that death occurred at 10:15 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 6/10/58 ACTUAL SIGNATURE Richard K. Shaw M.D. The Clinical Center The National Institutes of Health PHYSICIAN'S NAME (Type) Richard K. Shaw, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 6/10/58		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Rowe Cemetery		22d. LOCATION (City, town, or county) (State) Elkhart, Indiana	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE JUN 12 '58		24b. REGISTRAR'S SIGNATURE Alb...	

MEDICAL CERTIFICATION

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Date of registration	
13. Name of funeral home		14. Name of cemetery		15. Name of burial place	
16. Name of next of kin		17. Name of executor		18. Name of administrator	
19. Name of guardian		20. Name of trustee		21. Name of beneficiary	
22. Name of heir		23. Name of legatee		24. Name of devisee	
25. Name of assignee		26. Name of transferee		27. Name of mortgagee	
28. Name of lessee		29. Name of vendee		30. Name of purchaser	
31. Name of grantor		32. Name of grantee		33. Name of donor	
34. Name of donee		35. Name of testator		36. Name of executor	
37. Name of administrator		38. Name of guardian		39. Name of trustee	
40. Name of beneficiary		41. Name of heir		42. Name of legatee	
43. Name of devisee		44. Name of assignee		45. Name of transferee	
46. Name of mortgagee		47. Name of lessee		48. Name of vendee	
49. Name of purchaser		50. Name of grantor		51. Name of grantee	
52. Name of donor		53. Name of donee		54. Name of testator	
55. Name of executor		56. Name of administrator		57. Name of guardian	
58. Name of trustee		59. Name of beneficiary		60. Name of heir	
61. Name of legatee		62. Name of devisee		63. Name of assignee	
64. Name of transferee		65. Name of mortgagee		66. Name of lessee	
67. Name of vendee		68. Name of purchaser		69. Name of grantor	
70. Name of grantee		71. Name of donor		72. Name of donee	
73. Name of testator		74. Name of executor		75. Name of administrator	
76. Name of guardian		77. Name of trustee		78. Name of beneficiary	
79. Name of heir		80. Name of legatee		81. Name of devisee	
82. Name of assignee		83. Name of transferee		84. Name of mortgagee	
85. Name of lessee		86. Name of vendee		87. Name of purchaser	
88. Name of grantor		89. Name of grantee		90. Name of donor	
91. Name of donee		92. Name of testator		93. Name of executor	
94. Name of administrator		95. Name of guardian		96. Name of trustee	
97. Name of beneficiary		98. Name of heir		99. Name of legatee	
100. Name of devisee		101. Name of assignee		102. Name of transferee	
103. Name of mortgagee		104. Name of lessee		105. Name of vendee	
106. Name of purchaser		107. Name of grantor		108. Name of grantee	
109. Name of donor		110. Name of donee		111. Name of testator	
112. Name of executor		113. Name of administrator		114. Name of guardian	
115. Name of trustee		116. Name of beneficiary		117. Name of heir	
118. Name of legatee		119. Name of devisee		120. Name of assignee	
121. Name of transferee		122. Name of mortgagee		123. Name of lessee	
124. Name of vendee		125. Name of purchaser		126. Name of grantor	
127. Name of grantee		128. Name of donor		129. Name of donee	
130. Name of testator		131. Name of executor		132. Name of administrator	
133. Name of guardian		134. Name of trustee		135. Name of beneficiary	
136. Name of heir		137. Name of legatee		138. Name of devisee	
139. Name of assignee		140. Name of transferee		141. Name of mortgagee	
142. Name of lessee		143. Name of vendee		144. Name of purchaser	
145. Name of grantor		146. Name of grantee		147. Name of donor	
148. Name of donee		149. Name of testator		150. Name of executor	
151. Name of administrator		152. Name of guardian		153. Name of trustee	
154. Name of beneficiary		155. Name of heir		156. Name of legatee	
157. Name of devisee		158. Name of assignee		159. Name of transferee	
160. Name of mortgagee		161. Name of lessee		162. Name of vendee	
163. Name of purchaser		164. Name of grantor		165. Name of grantee	
166. Name of donor		167. Name of donee		168. Name of testator	
169. Name of executor		170. Name of administrator		171. Name of guardian	
172. Name of trustee		173. Name of beneficiary		174. Name of heir	
175. Name of legatee		176. Name of devisee		177. Name of assignee	
178. Name of transferee		179. Name of mortgagee		180. Name of lessee	
181. Name of vendee		182. Name of purchaser		183. Name of grantor	
184. Name of grantee		185. Name of donor		186. Name of donee	
187. Name of testator		188. Name of executor		189. Name of administrator	
190. Name of guardian		191. Name of trustee		192. Name of beneficiary	
193. Name of heir		194. Name of legatee		195. Name of devisee	
196. Name of assignee		197. Name of transferee		198. Name of mortgagee	
199. Name of lessee		200. Name of vendee		201. Name of purchaser	
202. Name of grantor		203. Name of grantee		204. Name of donor	
205. Name of donee		206. Name of testator		207. Name of executor	
208. Name of administrator		209. Name of guardian		210. Name of trustee	
211. Name of beneficiary		212. Name of heir		213. Name of legatee	
214. Name of devisee		215. Name of assignee		216. Name of transferee	
217. Name of mortgagee		218. Name of lessee		219. Name of vendee	
220. Name of purchaser		221. Name of grantor		222. Name of grantee	
223. Name of donor		224. Name of donee		225. Name of testator	
226. Name of executor		227. Name of administrator		228. Name of guardian	
229. Name of trustee		230. Name of beneficiary		231. Name of heir	
232. Name of legatee		233. Name of devisee		234. Name of assignee	
235. Name of transferee		236. Name of mortgagee		237. Name of lessee	
238. Name of vendee		239. Name of purchaser		240. Name of grantor	
241. Name of grantee		242. Name of donor		243. Name of donee	
244. Name of testator		245. Name of executor		246. Name of administrator	
247. Name of guardian		248. Name of trustee		249. Name of beneficiary	
250. Name of heir		251. Name of legatee		252. Name of devisee	
253. Name of assignee		254. Name of transferee		255. Name of mortgagee	
256. Name of lessee		257. Name of vendee		258. Name of purchaser	
259. Name of grantor		260. Name of grantee		261. Name of donor	
262. Name of donee		263. Name of testator		264. Name of executor	
265. Name of administrator		266. Name of guardian		267. Name of trustee	
268. Name of beneficiary		269. Name of heir		270. Name of legatee	
271. Name of devisee		272. Name of assignee		273. Name of transferee	
274. Name of mortgagee		275. Name of lessee		276. Name of vendee	
277. Name of purchaser		278. Name of grantor		279. Name of grantee	
280. Name of donor		281. Name of donee		282. Name of testator	
283. Name of executor		284. Name of administrator		285. Name of guardian	
286. Name of trustee		287. Name of beneficiary		288. Name of heir	
289. Name of legatee		290. Name of devisee		291. Name of assignee	
292. Name of transferee		293. Name of mortgagee		294. Name of lessee	
295. Name of vendee		296. Name of purchaser		297. Name of grantor	
298. Name of grantee		299. Name of donor		300. Name of donee	
301. Name of testator		302. Name of executor		303. Name of administrator	
304. Name of guardian		305. Name of trustee		306. Name of beneficiary	
307. Name of heir		308. Name of legatee		309. Name of devisee	
310. Name of assignee		311. Name of transferee		312. Name of mortgagee	
313. Name of lessee		314. Name of vendee		315. Name of purchaser	
316. Name of grantor		317. Name of grantee		318. Name of donor	
319. Name of donee		320. Name of testator		321. Name of executor	
322. Name of administrator		323. Name of guardian		324. Name of trustee	
325. Name of beneficiary		326. Name of heir		327. Name of legatee	
328. Name of devisee		329. Name of assignee		330. Name of transferee	
331. Name of mortgagee		332. Name of lessee		333. Name of vendee	
334. Name of purchaser		335. Name of grantor		336. Name of grantee	
337. Name of donor		338. Name of donee		339. Name of testator	
340. Name of executor		341. Name of administrator		342. Name of guardian	
343. Name of trustee		344. Name of beneficiary		345. Name of heir	
346. Name of legatee		347. Name of devisee		348. Name of assignee	
349. Name of transferee		350. Name of mortgagee		351. Name of lessee	
352. Name of vendee		353. Name of purchaser		354. Name of grantor	
355. Name of grantee		356. Name of donor		357. Name of donee	
358. Name of testator		359. Name of executor		360. Name of administrator	
361. Name of guardian		362. Name of trustee		363. Name of beneficiary	
364. Name of heir		365. Name of legatee		366. Name of devisee	
367. Name of assignee		368. Name of transferee		369. Name of mortgagee	
370. Name of lessee		371. Name of vendee		372. Name of purchaser	
373. Name of grantor		374. Name of grantee		375. Name of donor	
376. Name of donee		377. Name of testator		378. Name of executor	
379. Name of administrator		380. Name of guardian		381. Name of trustee	
382. Name of beneficiary		383. Name of heir		384. Name of legatee	
385. Name of devisee		386. Name of assignee		387. Name of transferee	
388. Name of mortgagee		389. Name of lessee		390. Name of vendee	
391. Name of purchaser		392. Name of grantor		393. Name of grantee	
394. Name of donor		395. Name of donee		396. Name of testator	
397. Name of executor		398. Name of administrator		399. Name of guardian	
400. Name of trustee		401. Name of beneficiary		402. Name of heir	
403. Name of legatee		404. Name of devisee		405. Name of assignee	
406. Name of transferee		407. Name of mortgagee		408. Name of lessee	
409. Name of vendee		410. Name of purchaser		411. Name of grantor	
412. Name of grantee		413. Name of donor		414. Name of donee	
415. Name of testator		416. Name of executor		417. Name of administrator	
418. Name of guardian		419. Name of trustee		420. Name of beneficiary	
421. Name of heir		422. Name of legatee		423. Name of devisee	
424. Name of assignee		425. Name of transferee		426. Name of mortgagee	
427. Name of lessee		428. Name of vendee		429. Name of purchaser	
430. Name of grantor		431. Name of grantee		432. Name of donor	
433. Name of donee		434. Name of testator		435. Name of executor	
436. Name of administrator		437. Name of guardian		438. Name of trustee	
439. Name of beneficiary		440. Name of heir		441. Name of legatee	
442. Name of devisee		443. Name of assignee		444. Name of transferee	
445. Name of mortgagee		446. Name of lessee		447. Name of vendee	
448. Name of purchaser		449. Name of grantor		450. Name of grantee	
451. Name of donor		452. Name of donee		453. Name of testator	
454. Name of executor		455. Name of administrator		456. Name of guardian	
457. Name of trustee		458. Name of beneficiary		459. Name of heir	
460. Name of legatee		461. Name of devisee		462. Name of assignee	
463. Name of transferee		464. Name of mortgagee		465. Name of lessee	
466. Name of vendee		467. Name of purchaser		468. Name of grantor	
469. Name of grantee		470. Name of donor		471. Name of donee	
472. Name of testator		473. Name of executor		474. Name of administrator	
475. Name of guardian		476. Name of trustee		477. Name of beneficiary	
478. Name of heir		479. Name of legatee		480. Name of devisee	
481. Name of assignee		482. Name of transferee		483. Name of mortgagee	
484. Name of lessee		485. Name of vendee		486. Name of purchaser	
487. Name of grantor		488. Name of grantee		489. Name of donor	
490. Name of donee		491. Name of testator		492. Name of executor	
493. Name of administrator		494. Name of guardian		495. Name of trustee	
496. Name of beneficiary		497. Name of heir		498. Name of legatee	
499. Name of devisee		500. Name of assignee		501. Name of transferee	
502. Name of mortgagee		503. Name of lessee		504. Name of vendee	
505. Name of purchaser		506. Name of grantor		507. Name of grantee	
508. Name of donor		509. Name of donee		510. Name of testator	
511. Name of executor		512. Name of administrator		513. Name of guardian	
514. Name of trustee		515. Name of beneficiary		516. Name of heir	
517. Name of legatee		518. Name of devisee		519. Name of assignee	
520. Name of transferee		521. Name of mortgagee		522. Name of lessee	
523. Name of vendee		524. Name of purchaser		525. Name of grantor	
526. Name of grantee		527. Name of donor		528. Name of donee	
529. Name of testator		530. Name of executor		531. Name of administrator	
532. Name of guardian		533. Name of trustee		534. Name of beneficiary	
535. Name of heir		536. Name of legatee		537. Name of devisee	
538. Name of assignee		539. Name of transferee		540. Name of mortgagee	
541. Name of lessee		542. Name of vendee		543. Name of purchaser	
544. Name of grantor		545. Name of grantee		546. Name of donor	
547. Name of donee		548. Name of testator		549. Name of executor	
550. Name of administrator		551. Name of guardian		552. Name of trustee	
553. Name of beneficiary		554. Name of heir		555. Name of legatee	
556. Name of devisee		557. Name of assignee		558. Name of transferee	
559. Name of mortgagee		560. Name of lessee		561. Name of vendee	
562. Name of purchaser		563. Name of grantor		564. Name of grantee	
565. Name of donor		566. Name of donee		567. Name of testator	
568. Name of executor		569. Name of administrator		570. Name of guardian	
571. Name of trustee		572. Name of beneficiary		573. Name of heir	
574. Name of legatee		575. Name of devisee		576. Name of assignee	
577. Name of transferee		578. Name of mortgagee		579. Name of lessee	
580. Name of vendee		581. Name of purchaser		582. Name of grantor	
583. Name of grantee		584. Name of donor		585. Name of donee	
586. Name of testator		587. Name of executor		588. Name of administrator	
589. Name of guardian		590. Name of trustee		591. Name of beneficiary	
592. Name of heir		593. Name of legatee		594. Name of devisee	
595. Name of assignee		596. Name of transferee		597. Name of mortgagee	
598. Name of lessee		599. Name of vendee		600. Name of purchaser	
601. Name of grantor		602. Name of grantee		603. Name of donor	
604. Name of donee		605. Name of testator		606. Name of executor	
607. Name of administrator		608. Name of guardian		609. Name of trustee	
610. Name of beneficiary		611. Name of heir		612. Name of legatee	
613. Name of devisee		614. Name of assignee		615. Name of transferee	
616. Name of mortgagee		617. Name of lessee		618. Name of vendee	
619. Name of purchaser		620. Name of grantor		621. Name of grantee	
622. Name of donor		623. Name of donee		624. Name of testator	
625. Name of executor		626. Name of administrator		627. Name of guardian	
628. Name of trustee		629. Name of beneficiary		630. Name of heir	
631. Name of legatee		632. Name of devisee		633. Name of assignee	
634. Name of transferee		635. Name of mortgagee		636. Name of lessee	
637. Name of vendee		638. Name of purchaser		639. Name of grantor	
640. Name of grantee		641. Name of donor		642. Name of donee	
643. Name of testator		644. Name of executor		645. Name of administrator	
646. Name of guardian		647. Name of trustee		648. Name of beneficiary	
649. Name of heir		650. Name of legatee		651. Name of devisee	
652. Name of assignee		653. Name of transferee		654. Name of mortgagee	
655. Name of lessee		656. Name of vendee		657. Name of purchaser	
658. Name of grantor		659. Name of grantee		660. Name of donor	
661. Name of donee		662. Name of testator		663. Name of executor	
664. Name of administrator		665. Name of guardian		666. Name of trustee	
667. Name of beneficiary		668. Name of heir		669. Name of legatee	
670. Name of devisee		671. Name of assignee		672. Name of transferee	
673. Name of mortgagee		674. Name of lessee		675. Name of vendee	
676. Name of purchaser		677. Name of grantor		678. Name of grantee	
679. Name of donor		680. Name of donee		681. Name of testator	
682. Name of executor		683. Name of administrator		684. Name of guardian	
685. Name of trustee		686. Name of beneficiary		687. Name of heir	
688. Name of legatee		689. Name of devisee		690. Name of assignee	
691. Name of transferee		692. Name of mortgagee		693. Name of lessee	
694. Name of vendee		695. Name of purchaser		696. Name of grantor	
697. Name of grantee		698. Name of donor		699. Name of donee	
700. Name of testator		701. Name of executor		702. Name of administrator	
703. Name of guardian		704. Name of trustee		705. Name of beneficiary	
706. Name of heir		707. Name of legatee		708. Name of devisee	
709. Name of assignee		710. Name of transferee		711. Name of mortgagee	
712. Name of lessee		713. Name of vendee		714. Name of purchaser	
715. Name of grantor		716. Name of grantee		717. Name of donor	
718. Name of donee		719. Name of testator		720. Name of executor	
721. Name of administrator		722. Name of guardian		723. Name of trustee	
724. Name of beneficiary		725. Name of heir		726. Name of legatee	
727. Name of devisee		728. Name of assignee		729. Name of transferee	
730. Name of mortgagee		731. Name of lessee		732. Name of vendee	
7					

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7034

CERTIFICATE OF DEATH

07013

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) AGNES L. KLINE		4. DATE OF DEATH June 26, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 19, 1874
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Calvin H. Lyon		14. MOTHER'S MAIDEN NAME Mary Chelaweth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT Robert Kline, Jr.		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) senility			INTERVAL BETWEEN ONSET AND DEATH 2 mo.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/25, 1958 to 6/26, 1958 that I last saw the deceased alive on 6/26, 1958 , and that death occurred at 1 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE S. W. Nealon Jr		ADDRESS (Street, city or town, state) 1746 K ST N. W.	
PHYSICIAN'S NAME (Type) Stephen W. Nealon, Jr.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6-27-58	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR JUN 30 '58		24b. REGISTRAR'S SIGNATURE W. H. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1902

DEATH RECORD

XX

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07014

6950

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash. D.C. NW 47th St</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>		d. STREET ADDRESS <u>5316 Nevada Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Bernard August Kober</u>		4. DATE OF DEATH <u>6-20-1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-30-92</u> 65 yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Pentagon Cafeteria</u>		9b. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
10a. NAME OF FATHER <u>Charles C. Kober</u>		10b. MOTHER'S MAIDEN NAME <u>Mary C. Brooker</u>	
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		12. SOCIAL SECURITY NO. <u>Pt. 25 Chart</u>	
13. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Cerebral Infarcts</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>2 1/2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? <u>YES</u> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> to <u>June 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 20</u> , 19 <u>58</u> , and that death occurred at <u>3:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James A. White</u>		ADDRESS (Street, city or town, state) <u>7701 Conall Ave</u> DATE SIGNED <u>6-20-58</u>	
PHYSICIAN'S NAME (Type) <u>T. K. ...</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-23-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forth Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deaf Funeral Home</u> ADDRESS <u>4812 Hallway</u>		24a. REC'D BY REGISTRAR <u>...</u> DATE <u>JUL 2 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>...</u>	

CERTIFICATE OF DEATH

1932

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

1. NAME

2. SEX

3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. PLACE OF DEATH

7. DATE OF DEATH

8. PLACE OF BIRTH

9. DATE OF BIRTH

10. PLACE OF DEATH

11. DATE OF DEATH

12. PLACE OF BIRTH

13. DATE OF BIRTH

14. PLACE OF DEATH

15. DATE OF DEATH

16. PLACE OF BIRTH

17. DATE OF BIRTH

18. PLACE OF DEATH

19. DATE OF DEATH

20. PLACE OF BIRTH

21. DATE OF BIRTH

22. PLACE OF DEATH

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33. DATE OF BIRTH

34. PLACE OF DEATH

35. DATE OF DEATH

36. PLACE OF BIRTH

37. DATE OF BIRTH

38. PLACE OF DEATH

39. DATE OF DEATH

~~unpublished after~~

General Infants

2 1/2 months

1

87-3-78

100-1-100

100-1-100

100-1-100

100-1-100

7035

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 708 G. Street, S. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Edward Last Leapley		4. DATE OF DEATH Month June Day 3 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 2, 1916	9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painting Business		11. BIRTHPLACE (State or foreign country) District of Columbia	
13. FATHER'S NAME Lewis D. Leapley		14. MOTHER'S MAIDEN NAME Nora V. Grant		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-12-6413		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) glioblastoma multiforme DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from May 23, 19 58 , to June 3, 19 58 , that I last saw the deceased alive on June 3, 19 58 , and that death occurred at 6:45 AM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Norman H. Bell		M.D. The Clinical Center		ADDRESS (Street, city or town, state) National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Norman H. Bell, M. D.		DATE SIGNED 6/3/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-6-58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
22d. LOCATION (City, town, or county) Switland		(State) md.			
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co		ADDRESS 517-11th St SE		24a. REC'D BY REGISTRAR DATE JUN 5 '58	
24b. REGISTRAR'S SIGNATURE Alberich					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

7036

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admision) o. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>224 Williamsburg Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>William</u> Middle <u>Lee</u> Last		4. DATE OF DEATH <u>June 24</u> 19 <u>58</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1-09</u>
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Undertaking</u>		11. BIRTHPLACE (State or foreign country) <u>D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Ernest C. Lee</u>		14. MOTHER'S MAIDEN NAME <u>Florence Rouse</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Ernest C Lee</u> Address <u>Father</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>420.1</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cobesity</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1954</u> to <u>24 June, 1958</u> , that I last saw the deceased alive on <u>24 June, 1958</u> , and that death occurred at <u>5:20 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William D. Carl</u> M.D.		ADDRESS (Street, city or town, state) <u>906 Coleville Rd Silver Spring, Md</u> DATE SIGNED <u>6/24/58</u>	
PHYSICIAN'S NAME (Type) <u>Lee Funeral Home - Wash. D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-27-58</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	22d. LOCATION (City, town, or county) (State) <u>Wash. D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - Wash. D.C.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>W. D. Carl</u> DATE <u>JUN 26 '58</u>	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2076

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		1881		BALTIMORE		MD		USA			
OCCUPATION		EDUCATION		MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY	
Carpenter		High School		Married		1905		BALTIMORE		MD		USA			
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		CITY		STATE		COUNTRY	
1925		BALTIMORE		Heart Disease		Natural		1925		BALTIMORE		MD		USA	
DATE OF INTERMENT		PLACE OF INTERMENT		CAUSE OF INTERMENT		MANNER OF INTERMENT		CERTIFICATE OF INTERMENT		CITY		STATE		COUNTRY	
1925		BALTIMORE		Heart Disease		Natural		1925		BALTIMORE		MD		USA	
DATE OF BURIAL		PLACE OF BURIAL		CAUSE OF BURIAL		MANNER OF BURIAL		CERTIFICATE OF BURIAL		CITY		STATE		COUNTRY	
1925		BALTIMORE		Heart Disease		Natural		1925		BALTIMORE		MD		USA	
DATE OF CREMATION		PLACE OF CREMATION		CAUSE OF CREMATION		MANNER OF CREMATION		CERTIFICATE OF CREMATION		CITY		STATE		COUNTRY	
1925		BALTIMORE		Heart Disease		Natural		1925		BALTIMORE		MD		USA	
DATE OF EXHUMATION		PLACE OF EXHUMATION		CAUSE OF EXHUMATION		MANNER OF EXHUMATION		CERTIFICATE OF EXHUMATION		CITY		STATE		COUNTRY	
1925		BALTIMORE		Heart Disease		Natural		1925		BALTIMORE		MD		USA	
DATE OF REINTERMENT		PLACE OF REINTERMENT		CAUSE OF REINTERMENT		MANNER OF REINTERMENT		CERTIFICATE OF REINTERMENT		CITY		STATE		COUNTRY	
1925		BALTIMORE		Heart Disease		Natural		1925		BALTIMORE		MD		USA	

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7037

Item 9 File G230 6-25-58 et

CERTIFICATE OF DEATH

07017

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>			c. LENGTH OF STAY IN 1b <u>13 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>				d. STREET ADDRESS <u>/</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maude</u> Middle <u>—</u> Last <u>Lee</u>				4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/9/29</u>		9. AGE (In years last birthday) <u>29</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		
13. FATHER'S NAME <u>Hugh Rounds</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Newman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Richard E. Lee</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial insufficiency</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac dilatation and hypertrophy</u> DUE TO (c) <u>Pulmonary hypertension.</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/4</u> , 19 <u>58</u> to <u>6/5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/5</u> , 19 <u>58</u> , and that death occurred at <u>8:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>C. H. Ligon, M. D.</u>				<u>Sandy Spring, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial,</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Ligon</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 13 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

CERTIFICATE OF DEATH

1933

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. DATE OF BIRTH [REDACTED]</p>	
<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. OCCUPATION [REDACTED]</p>	
<p>7. MARITAL STATUS [REDACTED]</p>		<p>8. CAUSE OF DEATH [REDACTED]</p>	
<p>9. MEDICAL HISTORY [REDACTED]</p>		<p>10. HISTORY OF PRESENT ILLNESS [REDACTED]</p>	
<p>11. PHYSICIAN'S SIGNATURE [REDACTED]</p>		<p>12. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>13. SIGNATURE OF WITNESS [REDACTED]</p>		<p>14. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>15. SIGNATURE OF WITNESS [REDACTED]</p>		<p>16. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>17. SIGNATURE OF WITNESS [REDACTED]</p>		<p>18. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>19. SIGNATURE OF WITNESS [REDACTED]</p>		<p>20. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>21. SIGNATURE OF WITNESS [REDACTED]</p>		<p>22. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>23. SIGNATURE OF WITNESS [REDACTED]</p>		<p>24. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>25. SIGNATURE OF WITNESS [REDACTED]</p>		<p>26. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>27. SIGNATURE OF WITNESS [REDACTED]</p>		<p>28. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>29. SIGNATURE OF WITNESS [REDACTED]</p>		<p>30. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>31. SIGNATURE OF WITNESS [REDACTED]</p>		<p>32. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>33. SIGNATURE OF WITNESS [REDACTED]</p>		<p>34. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>35. SIGNATURE OF WITNESS [REDACTED]</p>		<p>36. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>37. SIGNATURE OF WITNESS [REDACTED]</p>		<p>38. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>39. SIGNATURE OF WITNESS [REDACTED]</p>		<p>40. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>41. SIGNATURE OF WITNESS [REDACTED]</p>		<p>42. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>43. SIGNATURE OF WITNESS [REDACTED]</p>		<p>44. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>45. SIGNATURE OF WITNESS [REDACTED]</p>		<p>46. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>47. SIGNATURE OF WITNESS [REDACTED]</p>		<p>48. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>49. SIGNATURE OF WITNESS [REDACTED]</p>		<p>50. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>51. SIGNATURE OF WITNESS [REDACTED]</p>		<p>52. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>53. SIGNATURE OF WITNESS [REDACTED]</p>		<p>54. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>55. SIGNATURE OF WITNESS [REDACTED]</p>		<p>56. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>57. SIGNATURE OF WITNESS [REDACTED]</p>		<p>58. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>59. SIGNATURE OF WITNESS [REDACTED]</p>		<p>60. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>61. SIGNATURE OF WITNESS [REDACTED]</p>		<p>62. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>63. SIGNATURE OF WITNESS [REDACTED]</p>		<p>64. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>65. SIGNATURE OF WITNESS [REDACTED]</p>		<p>66. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>67. SIGNATURE OF WITNESS [REDACTED]</p>		<p>68. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>69. SIGNATURE OF WITNESS [REDACTED]</p>		<p>70. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>71. SIGNATURE OF WITNESS [REDACTED]</p>		<p>72. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>73. SIGNATURE OF WITNESS [REDACTED]</p>		<p>74. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>75. SIGNATURE OF WITNESS [REDACTED]</p>		<p>76. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>77. SIGNATURE OF WITNESS [REDACTED]</p>		<p>78. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>79. SIGNATURE OF WITNESS [REDACTED]</p>		<p>80. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>81. SIGNATURE OF WITNESS [REDACTED]</p>		<p>82. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>83. SIGNATURE OF WITNESS [REDACTED]</p>		<p>84. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>85. SIGNATURE OF WITNESS [REDACTED]</p>		<p>86. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>87. SIGNATURE OF WITNESS [REDACTED]</p>		<p>88. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>89. SIGNATURE OF WITNESS [REDACTED]</p>		<p>90. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>91. SIGNATURE OF WITNESS [REDACTED]</p>		<p>92. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>93. SIGNATURE OF WITNESS [REDACTED]</p>		<p>94. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>95. SIGNATURE OF WITNESS [REDACTED]</p>		<p>96. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>97. SIGNATURE OF WITNESS [REDACTED]</p>		<p>98. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>99. SIGNATURE OF WITNESS [REDACTED]</p>		<p>100. SIGNATURE OF DECEASED [REDACTED]</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7038 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07018

Reg. Disf. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	c. LENGTH OF STAY IN 1b 20 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 716 Chesapeake Avenue		d. STREET ADDRESS 716 Chesapeake Avenue	
3. NAME OF DECEASED (Type or print) Della		4. DATE OF DEATH Month June Day 10 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1898
9. AGE (in years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days 	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (retired)		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME William D'Edwine		14. MOTHER'S MAIDEN NAME Kathryn Cottrell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Edna M. Laurence, 20 Beach Ave., Elsmere, Delaware		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/10/1958	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6/13/58	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY	22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.	24a. REC'D BY REGISTRAR DATE JUN 13 58
24b. REGISTRAR'S SIGNATURE W. E. Humphrey			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6951 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07019
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring,</u> d. STREET ADDRESS <u>18603 Milford Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert</u> <u>Milmore</u> <u>Leishear</u>				4. DATE OF DEATH Month Day Year <u>6</u> - <u>11</u> - <u>1958</u>													
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-19-1906</u>		9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Jeweler</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Jewelry</u>				11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>					
13. FATHER'S NAME <u>William J. Leishear</u>								14. MOTHER'S MAIDEN NAME <u>Ida Bowler</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>578-18-5573</u>				17. INFORMANT Address <u>Mrs. Helen Louise Leishear -- same</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.								CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED					
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>								ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				<u>6-11-58</u>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>6/11/58</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Jones Co. 2901-14th St. N. W.</u>								ADDRESS				24a. REC'D BY REGISTRAR <u>6-11-58</u>				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7039
CERTIFICATE OF DEATH

07020

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mont. Co. Gen. Hospital		d. STREET ADDRESS 06x-2	
3. NAME OF DECEASED (Type or print) First Baby Girl Middle Lindsay Last Lindsay		4. DATE OF DEATH Month June Day 27 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1958
9. AGE (In years last birthday) yrs. 23		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY MD.	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Roy George Lindsay		14. MOTHER'S MAIDEN NAME Ellen M. Greenwood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not, or unknown) No		16. SOCIAL SECURITY NO. #####	
17. INFORMANT Roy G. Lindsay		Address Same As 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fetal distention DUE TO 762.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____			
INTERVAL BETWEEN ONSET AND DEATH 23 min			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/27, 1958 , to 6/27, 1958 , that I last saw the deceased alive on 6/27, 1958 , and that death occurred at 3:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED Red 6/27/58			
ACTUAL SIGNATURE A.D. Bonifant		M.D. Samuel S. Spay	
PHYSICIAN'S NAME (Type) A.D. BONIFANT			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 28	
22c. NAME OF CEMETERY OR CREMATORY Laytonsville, Meth		22d. LOCATION (City, town, or county) (State) Laytonsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Roy W. Barber		ADDRESS Laytonsville, Md.	
24a. REC'D BY REGISTRAR JUL 7 '58		24b. REGISTRAR'S SIGNATURE W. Leach	

2073253XVO

CERTIFICATE OF DEATH

1900

<p>1. Name of deceased: JOHN WILLIAMS</p>		<p>2. Sex: Male</p>	
<p>3. Age: 45</p>		<p>4. Date of birth: Jan 15, 1855</p>	
<p>5. Place of birth: Massachusetts</p>		<p>6. Date of death: Dec 10, 1900</p>	
<p>7. Cause of death: Heart Disease</p>		<p>8. Place of death: Home</p>	
<p>9. Signature of physician: Dr. J. B. Smith</p>		<p>10. Signature of registrar: John A. Jones</p>	
<p>11. Date of certificate: Dec 15, 1900</p>		<p>12. Office of registrar: Boston</p>	

CERTIFICATE OF DEATH

7040

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Surinam b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Franklin Leslie Liqui-Lung		4. DATE OF DEATH Month Day Year June 26 1958	
5. SEX Male	6. COLOR OR RACE Yellow	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1930
9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Surinam		12. CITIZEN OF WHAT COUNTRY? Surinam ✓	
13. FATHER'S NAME Fritz Liqui-Lung		14. MOTHER'S MAIDEN NAME Matilda Tjon-A-Sie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Cerebral + abdominal visceral emboli DUE TO (c) Rheumatic Heart Disease with Mitral Stenosis		INTERVAL BETWEEN ONSET AND DEATH 1 hour 30 hours 15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 13, 1958 , to June 26, 1958 , that I last saw the deceased alive on June 26, 1958 , and that death occurred at 8:05 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John A. Waldhausen		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 6/28/58	
PHYSICIAN'S NAME (Type) John A. Waldhausen, M.D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/1/58	22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	22d. LOCATION (City, town, or county) (State) Silver Spring, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR JUN 30 1958 24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Five, four, three, two, one

Items 2 & 11, File G231, 7/11/58

7041

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 4 hrs. 20"		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) Suburban				d. STREET ADDRESS 2619 Woodley Place,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Girl Middle Luethy Last				4. DATE OF DEATH Month June Day 26 Year 1958			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 26 1958		9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR Months Days Hours Min
						4 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Montg. Co., Maryland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME Elizabeth M Luethy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Wash., D. C. Elizabeth M Luethy, 2619 Woodley Pl.	
18. CAUSE OF DEATH [Enter only one cause per line or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Immaturity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:30 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Geo A Maxwell M.D. 121 So. Washington St, Rockville, Md.				PHYSICIAN'S NAME (Type) George A. Maxwell, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 7-2-58		22c. NAME OF CEMETERY OR CREMATORY Suburban Hosp.		22d. LOCATION (City, town, or county) (State) Bethesda, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. RECEIVED BY REGISTRAR DATE JUL 8 1958		24b. REGISTRAR'S SIGNATURE W. Beduch	

207433VXVO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6961

CERTIFICATE OF DEATH

Reg. Dist. No.

07023

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>20 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>208 Monroe Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>G</u> Last <u>MARTH</u>				4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1883</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder-retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own business</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Leonard Marth</u>				14. MOTHER'S MAIDEN NAME <u>Augusta Groendroff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Virginia Munday- same as d2 daughter</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLUS</u> <u>464X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Branch of A.S.I.</u> DUE TO (c) <u>+ HYPERTROPHIC CARDIOMYOPATHY</u>						INTERVAL BETWEEN ONSET AND DEATH <u>TEN HOURS</u> <u>TEN YEARS</u> <u>6 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>MARCH 30, 1958</u> , to <u>JUNE 1, 1958</u> , that I last saw the deceased alive on <u>MAY 27, 1958</u> , and that death occurred at <u>7 A</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>26 N. Summit Ave. Rockville, Md.</u> DATE SIGNED <u>June 2, 1958</u>							
ACTUAL SIGNATURE <u>Gordon S. Rosenberger</u>				PHYSICIAN'S NAME (Type) <u>Gordon S. Rosenberger</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cem. Assoc</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE JUN 4 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 07024

7042

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bradford Rest Home		e. IS RESIDENCE ON A FARM? * YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Mathews Last Mathews		4. DATE OF DEATH Month June Day 8 Year 1958	
5. SEX male	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12 1892
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66	IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min. 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilson Matthews		14. MOTHER'S MAIDEN NAME Margaret Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Elwood Mathews		Address Fairland Road., Silver Spring, Md. Route # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coma, Hemiplegia. 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiorenal Disease DUE TO (c) Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arthritis. Cataract.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 28 1946 , to June 8 1958 , that I last saw the deceased alive on June 7 1958 , and that death occurred at 1:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Norbeck Rt 1 Silver Spring Md. DATE SIGNED Webster Sewell 6/10/58			
ACTUAL SIGNATURE Webster Sewell		M.D. Norbeck Rt 1 Silver Spring Md.	
PHYSICIAN'S NAME (Type) Webster Sewell			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	6/11/58	Good Hope	Colesville Md
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md	
24a. REC'D BY REGISTRAR DATE JUN 16 '58		24b. REGISTRAR'S SIGNATURE W. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 308, LBJ Library, Washington, D.C.	
7. CAUSE OF DEATH Suicide by gunshot wound of the chest		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Jackson, Mississippi	
10. DATE OF BIRTH January 19, 1933		11. SEX OF BIRTH Male		12. AGE AT BIRTH 35	
13. DATE OF DEATH April 4, 1968		14. TIME OF DEATH 2:01 PM		15. PLACE OF DEATH Room 308, LBJ Library, Washington, D.C.	
16. CAUSE OF DEATH Suicide by gunshot wound of the chest		17. MANNER OF DEATH Homicide		18. PLACE OF BIRTH Jackson, Mississippi	
19. DATE OF BIRTH January 19, 1933		20. SEX OF BIRTH Male		21. AGE AT BIRTH 35	
22. DATE OF DEATH April 4, 1968		23. TIME OF DEATH 2:01 PM		24. PLACE OF DEATH Room 308, LBJ Library, Washington, D.C.	
25. CAUSE OF DEATH Suicide by gunshot wound of the chest		26. MANNER OF DEATH Homicide		27. PLACE OF BIRTH Jackson, Mississippi	
28. DATE OF BIRTH January 19, 1933		29. SEX OF BIRTH Male		30. AGE AT BIRTH 35	
31. DATE OF DEATH April 4, 1968		32. TIME OF DEATH 2:01 PM		33. PLACE OF DEATH Room 308, LBJ Library, Washington, D.C.	
34. CAUSE OF DEATH Suicide by gunshot wound of the chest		35. MANNER OF DEATH Homicide		36. PLACE OF BIRTH Jackson, Mississippi	
37. DATE OF BIRTH January 19, 1933		38. SEX OF BIRTH Male		39. AGE AT BIRTH 35	
40. DATE OF DEATH April 4, 1968		41. TIME OF DEATH 2:01 PM		42. PLACE OF DEATH Room 308, LBJ Library, Washington, D.C.	
43. CAUSE OF DEATH Suicide by gunshot wound of the chest		44. MANNER OF DEATH Homicide		45. PLACE OF BIRTH Jackson, Mississippi	
46. DATE OF BIRTH January 19, 1933		47. SEX OF BIRTH Male		48. AGE AT BIRTH 35	
49. DATE OF DEATH April 4, 1968		50. TIME OF DEATH 2:01 PM		51. PLACE OF DEATH Room 308, LBJ Library, Washington, D.C.	
52. CAUSE OF DEATH Suicide by gunshot wound of the chest		53. MANNER OF DEATH Homicide		54. PLACE OF BIRTH Jackson, Mississippi	
55. DATE OF BIRTH January 19, 1933		56. SEX OF BIRTH Male		57. AGE AT BIRTH 35	
58. DATE OF DEATH April 4, 1968		59. TIME OF DEATH 2:01 PM		60. PLACE OF DEATH Room 308, LBJ Library, Washington, D.C.	
61. CAUSE OF DEATH Suicide by gunshot wound of the chest		62. MANNER OF DEATH Homicide		63. PLACE OF BIRTH Jackson, Mississippi	
64. DATE OF BIRTH January 19, 1933		65. SEX OF BIRTH Male		66. AGE AT BIRTH 35	
67. DATE OF DEATH April 4, 1968		68. TIME OF DEATH 2:01 PM		69. PLACE OF DEATH Room 308, LBJ Library, Washington, D.C.	
70. CAUSE OF DEATH Suicide by gunshot wound of the chest		71. MANNER OF DEATH Homicide		72. PLACE OF BIRTH Jackson, Mississippi	
73. DATE OF BIRTH January 19, 1933		74. SEX OF BIRTH Male		75. AGE AT BIRTH 35	
76. DATE OF DEATH April 4, 1968		77. TIME OF DEATH 2:01 PM		78. PLACE OF DEATH Room 308, LBJ Library, Washington, D.C.	
79. CAUSE OF DEATH Suicide by gunshot wound of the chest		80. MANNER OF DEATH Homicide		81. PLACE OF BIRTH Jackson, Mississippi	
82. DATE OF BIRTH January 19, 1933		83. SEX OF BIRTH Male		84. AGE AT BIRTH 35	
85. DATE OF DEATH April 4, 1968		86. TIME OF DEATH 2:01 PM		87. PLACE OF DEATH Room 308, LBJ Library, Washington, D.C.	
88. CAUSE OF DEATH Suicide by gunshot wound of the chest		89. MANNER OF DEATH Homicide		90. PLACE OF BIRTH Jackson, Mississippi	
91. DATE OF BIRTH January 19, 1933		92. SEX OF BIRTH Male		93. AGE AT BIRTH 35	
94. DATE OF DEATH April 4, 1968		95. TIME OF DEATH 2:01 PM		96. PLACE OF DEATH Room 308, LBJ Library, Washington, D.C.	
97. CAUSE OF DEATH Suicide by gunshot wound of the chest		98. MANNER OF DEATH Homicide		99. PLACE OF BIRTH Jackson, Mississippi	
100. DATE OF BIRTH January 19, 1933		101. SEX OF BIRTH Male		102. AGE AT BIRTH 35	

REGISTERED MEDICAL

1. This certificate is to be filled out by the attending physician or other qualified person who has attended the deceased during his or her last illness. It should be filled out as soon as possible after death, but not later than 72 hours after death. It should be signed by the attending physician or other qualified person who has attended the deceased during his or her last illness. It should be filed with the local health department or other authority having jurisdiction over the death. It should be made available to the public upon request.

7043

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 8 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9000 COLUMBIA BLVD.			d. STREET ADDRESS 1, 9000 COLUMBIA BLVD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HAROLD Middle CRITSLOW Last McGOWAN			4. DATE OF DEATH Month JUNE Day 11 Year 19 58		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/12/1900	9. AGE (in years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) OHIO	
13. FATHER'S NAME Harry McGowan			14. MOTHER'S MAIDEN NAME Suella Cole		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW 1 272-18-6433		17. INFORMANT Address Mrs. Gertrude McGowan, wife, Same as item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 9773.1 DUE TO Carbon monoxide poisoning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Found dead in car in closed garage					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/11/58	
EXAMINER'S NAME (Type) FRANK J. BROSCHART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 6/14/58		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory	
22d. LOCATION (City, town, or county) (State) Prince Geo. County, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Humphrey</i>		ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR JUN 16 58 24b. REGISTRAR'S SIGNATURE <i>W. E. Humphrey</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

7044

CERTIFICATE OF DEATH

Reg. Dist. No.

215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 5 hr. 15 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park 18X-2 ✓	
f. STREET ADDRESS 391 Chinlee Drive		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle (nmn) Last MC KISSICK		4. DATE OF DEATH Month June Day 30 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-30-58
9. AGE (In years lost birthday) yrs. 10		IF UNDER 1 YEAR Months 10 Days 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert MC KISSICK		14. MOTHER'S MAIDEN NAME Margaret MC CULLOUGH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Robert MC KISICK (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 762.5 IMMEDIATE CAUSE (a) Primary Atelectasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Immaturity DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 30 June , 19 58 , to 30 June , 19 58 , that I last saw the deceased alive on 30 June , 19 58 , and that death occurred at 8:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. C. Parke Jr.		DATE SIGNED 7-2-58	
PHYSICIAN'S NAME (Type) J. C. PARKE JR., LT MC USN		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-7-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave, Bethesda, Md		24a. REC'D BY REGISTRAR JUL 8 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE W. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only even within 72 hours after death.

2051223XVV

STATE DEPARTMENT OF HEALTH - BALTIMORE 15

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07027

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>2801 Sheraton St.</u>	
3. NAME OF DECEASED (Type or print) <u>Charles HENRY McMullen</u>		4. DATE OF DEATH Month <u>6</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-28-18</u>
9. AGE (In years last birthday) <u>39</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>	
11. BIRTHPLACE (State or foreign country) <u>PENN.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles H. McMullen</u>		14. MOTHER'S MAIDEN NAME <u>Anna B. Voswinkle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WW2</u>		16. SOCIAL SECURITY NO. <u>201-01-5747</u>	
17. INFORMANT <u>Mrs. Phyllis E. McMullen</u>		Address <u>2801 Sheraton Rd. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/2/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>JUL 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Humphrey</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH HAWAIIAN STATE DEPARTMENT OF HEALTH - HONOLULU

NAME OF DECEASED [Handwritten: JOHN DOE]		SEX [Handwritten: Male]	
AGE [Handwritten: 45]		DATE OF BIRTH [Handwritten: 10/15/1925]	
PLACE OF BIRTH [Handwritten: Honolulu, Hawaii]		OCCUPATION [Handwritten: Teacher]	
MARITAL STATUS [Handwritten: Married]		DATE OF MARRIAGE [Handwritten: 08/10/1950]	
NAME OF SPOUSE [Handwritten: Jane Doe]		ADDRESS [Handwritten: 123 Main St, Honolulu, HI 96813]	
DATE OF DEATH [Handwritten: 11/20/1975]		TIME OF DEATH [Handwritten: 10:15 AM]	
PLACE OF DEATH [Handwritten: Home]		CAUSE OF DEATH [Handwritten: Myocardial Infarction]	
MANNER OF DEATH [Handwritten: Natural]		SIGNATURE OF EXAMINER [Handwritten: Dr. John Smith]	
SIGNATURE OF WITNESS [Handwritten: Jane Doe]		SIGNATURE OF NEXT OF KIN [Handwritten: John Doe]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07028

Reg. Dist. No.

Item 18 Film 231 7-7-58

7046

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Mongtomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mongtomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Onley</u>		c. LENGTH OF STAY IN lb <u>15 min.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville 26</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mongtomery County General Hospital</u>			d. STREET ADDRESS <u>16209 Emory Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Opal</u> Middle <u>Ella</u> Last <u>Michels</u>			4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29, 1894</u>		9. AGE (in years last birthday) <u>64 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Neb.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>David Taylor</u>			14. MOTHER'S MAIDEN NAME <u>Sue Nutt</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>F. A. Michels (husband)</u> Address <u>Item 2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic heart disease</u> DUE TO (c) <u>Bronchial Asthma</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>?</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		22b. DATE THEREOF <u>6/16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CROWN HILL CEMETERY</u>	
				22d. LOCATION (City, town, or county) (State) <u>Denver, Colorado</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wesley S. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>6/16/58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wesley S. Humphrey</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		45		Male		White		March 28, 1928		Home	
Cause of Death		Disease		Injury		Poison		Other		Manner of Death	
Heart Disease		Coronary Artery Sclerosis		Myocardial Infarction		Hypertension		Atherosclerosis		Natural	
Contributing Cause		Hypertension		Atherosclerosis		Coronary Artery Sclerosis		Myocardial Infarction		Natural	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Juror		Signature of Witness		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Examination		Time of Examination		Place of Examination		Name of Hospital		Name of Doctor		Name of Nurse	
March 28, 1928		10:00 AM		Home		St. Mary's Hospital		Dr. J. Doe		Miss M. Doe	

7047

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 2 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1909 ROOKWOOD ROAD		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 1909 ROOKWOOD ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ESTELLA LOUISA MILLER First Middle Last		4. DATE OF DEATH June 15 1958 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 6, 1870
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) GORDON, PA.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME JAMES M. SEITZINGER	
14. MOTHER'S MAIDEN NAME SARAH ANN EBERT		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT JAMES E. MILLER, 1909 ROOKWOOD RD., SILVER SPRING Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) years		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from March 1945 to June 15, 1958 , that I last saw the deceased alive on June 14, 1958 , and that death occurred on June 15, 1958 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1919 Seminary Rd Silver Spring, Md. DATE SIGNED June 15, 1958	
ACTUAL SIGNATURE John S. Rogers		PHYSICIAN'S NAME (Type) JOHN S. ROGERS	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 6/18/58	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) Prince George County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS Silver Spring, Md.	
24a. REC'D BY REGISTRAR JUN 17 '58		24b. REGISTRAR'S SIGNATURE Arthur	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

REG. NO. 100

COUNTY OF <u>ALLEGANY</u> STATE OF <u>MD</u>		DECEASED <u>JOHN J. HARRIS</u>	
DATE OF DEATH <u>10-15-1914</u> PLACE OF DEATH <u>HOME</u>		AGE <u>65</u> SEX <u>M</u>	
OCCUPATION <u>LABORER</u> CAUSE OF DEATH <u>HEART DISEASE</u>		MEDICAL ATTENDANT <u>DR. J. H. HARRIS</u> PLACE OF BURIAL <u>HOME</u>	
SIGNATURE OF DECEASED <u>JOHN J. HARRIS</u> SIGNATURE OF MEDICAL ATTENDANT <u>DR. J. H. HARRIS</u>		SIGNATURE OF REGISTRAR <u>J. H. HARRIS</u> DATE <u>10-15-1914</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6952 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07030

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery, Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Pr. William</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Pk. Md</u>		c. LENGTH OF STAY IN 1b <u>D.D.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Haymarket 83x-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. Hosp</u>				d. STREET ADDRESS <u>Prince William</u>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Eugene</u> Last <u>Moose</u>				4. DATE OF DEATH Month <u>6</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>wh</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Dec 23 - 1898</u>		9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical business</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Clarence Hepler</u>					
14. MOTHER'S MAIDEN NAME <u>Mrs Daisy Hepler</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Edith M Moose (wife)</u> Address <u>Stm 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage & lacunar</u> 976x DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Compound fracture of skull</u> (c) <u>shot gun wound</u> DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with shot gun in bed room of daughter's home</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>1:30</u> o. m. <u>6-7</u> p. m. <u>1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>7215 15th Ave</u>			
20f. (City or town) <u>Takoma Park</u>		20g. (County) <u>P.G.</u>		20h. (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6-7-58</u>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCH M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REINTERMENT (Specify) <u>6-11-58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Cal. Nat Cem</u>			
22d. LOCATION (City, town, or county) <u>Fort Myer - Va.</u>		22e. (State) <u> </u>		24a. REC'D BY REGISTRAR <u>JUN 10 58</u>			
24b. REGISTRAR'S SIGNATURE <u>J. W. E. Lusk</u>		ADDRESS <u>Wash. D.C.</u>		24c. DATE <u> </u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED _____</p>		<p>2. SEX _____</p>	
<p>3. AGE _____</p>		<p>4. DATE OF BIRTH _____</p>	
<p>5. PLACE OF BIRTH _____</p>		<p>6. OCCUPATION _____</p>	
<p>7. MARITAL STATUS _____</p>		<p>8. EDUCATION _____</p>	
<p>9. PRESENT ADDRESS _____</p>		<p>10. DATE OF DEATH _____</p>	
<p>11. CAUSE OF DEATH _____</p>		<p>12. MANNER OF DEATH _____</p>	
<p>13. SIGNATURE OF EXAMINER _____</p>		<p>14. SIGNATURE OF WITNESS _____</p>	
<p>15. SIGNATURE OF DECEASED _____</p>		<p>16. SIGNATURE OF NEXT OF KIN _____</p>	
<p>17. SIGNATURE OF PHYSICIAN _____</p>		<p>18. SIGNATURE OF JURY _____</p>	
<p>19. SIGNATURE OF CORONER _____</p>		<p>20. SIGNATURE OF JUDGE _____</p>	
<p>21. SIGNATURE OF CLERK _____</p>		<p>22. SIGNATURE OF RECORDS _____</p>	
<p>23. SIGNATURE OF ATTORNEY _____</p>		<p>24. SIGNATURE OF SHERIFF _____</p>	
<p>25. SIGNATURE OF DEPUTY SHERIFF _____</p>		<p>26. SIGNATURE OF CONSTABLE _____</p>	
<p>27. SIGNATURE OF TOWNSHIP CLERK _____</p>		<p>28. SIGNATURE OF VOTING CLERK _____</p>	
<p>29. SIGNATURE OF TOWN CLERK _____</p>		<p>30. SIGNATURE OF COUNTY CLERK _____</p>	
<p>31. SIGNATURE OF STATE CLERK _____</p>		<p>32. SIGNATURE OF FEDERAL CLERK _____</p>	
<p>33. SIGNATURE OF POSTAL CLERK _____</p>		<p>34. SIGNATURE OF TELEGRAPH CLERK _____</p>	
<p>35. SIGNATURE OF RAILROAD CLERK _____</p>		<p>36. SIGNATURE OF AIRLINE CLERK _____</p>	
<p>37. SIGNATURE OF MARINE CLERK _____</p>		<p>38. SIGNATURE OF NAVY CLERK _____</p>	
<p>39. SIGNATURE OF ARMY CLERK _____</p>		<p>40. SIGNATURE OF AIR FORCE CLERK _____</p>	
<p>41. SIGNATURE OF SPACE CLERK _____</p>		<p>42. SIGNATURE OF DEFENSE CLERK _____</p>	
<p>43. SIGNATURE OF INTELLIGENCE CLERK _____</p>		<p>44. SIGNATURE OF SECURITY CLERK _____</p>	
<p>45. SIGNATURE OF POLICE CLERK _____</p>		<p>46. SIGNATURE OF FIRE DEPARTMENT CLERK _____</p>	
<p>47. SIGNATURE OF SANITATION CLERK _____</p>		<p>48. SIGNATURE OF PUBLIC WORKS CLERK _____</p>	
<p>49. SIGNATURE OF PARKS CLERK _____</p>		<p>50. SIGNATURE OF RECREATION CLERK _____</p>	
<p>51. SIGNATURE OF CULTURAL CLERK _____</p>		<p>52. SIGNATURE OF ARTS CLERK _____</p>	
<p>53. SIGNATURE OF SCIENCE CLERK _____</p>		<p>54. SIGNATURE OF TECHNOLOGY CLERK _____</p>	
<p>55. SIGNATURE OF BUSINESS CLERK _____</p>		<p>56. SIGNATURE OF FINANCE CLERK _____</p>	
<p>57. SIGNATURE OF LEGAL CLERK _____</p>		<p>58. SIGNATURE OF JUDICIAL CLERK _____</p>	
<p>59. SIGNATURE OF EXECUTIVE CLERK _____</p>		<p>60. SIGNATURE OF ADMINISTRATIVE CLERK _____</p>	
<p>61. SIGNATURE OF SUPPORT CLERK _____</p>		<p>62. SIGNATURE OF OPERATIONS CLERK _____</p>	
<p>63. SIGNATURE OF MAINTENANCE CLERK _____</p>		<p>64. SIGNATURE OF LOGISTICS CLERK _____</p>	
<p>65. SIGNATURE OF SUPPLY CLERK _____</p>		<p>66. SIGNATURE OF PROCUREMENT CLERK _____</p>	
<p>67. SIGNATURE OF CONTRACTS CLERK _____</p>		<p>68. SIGNATURE OF PROPERTY CLERK _____</p>	
<p>69. SIGNATURE OF RECORDS CLERK _____</p>		<p>70. SIGNATURE OF INFORMATION CLERK _____</p>	
<p>71. SIGNATURE OF COMMUNICATIONS CLERK _____</p>		<p>72. SIGNATURE OF TRANSPORTATION CLERK _____</p>	
<p>73. SIGNATURE OF TRAVEL CLERK _____</p>		<p>74. SIGNATURE OF ACCOMMODATIONS CLERK _____</p>	
<p>75. SIGNATURE OF FOOD AND BEVERAGE CLERK _____</p>		<p>76. SIGNATURE OF RETAIL CLERK _____</p>	
<p>77. SIGNATURE OF WHOLESALE CLERK _____</p>		<p>78. SIGNATURE OF MANUFACTURING CLERK _____</p>	
<p>79. SIGNATURE OF CONSTRUCTION CLERK _____</p>		<p>80. SIGNATURE OF UTILITIES CLERK _____</p>	
<p>81. SIGNATURE OF ENERGY CLERK _____</p>		<p>82. SIGNATURE OF ENVIRONMENTAL CLERK _____</p>	
<p>83. SIGNATURE OF NATURAL RESOURCES CLERK _____</p>		<p>84. SIGNATURE OF AGRICULTURE CLERK _____</p>	
<p>85. SIGNATURE OF FORESTRY CLERK _____</p>		<p>86. SIGNATURE OF FISHERIES CLERK _____</p>	
<p>87. SIGNATURE OF WILDLIFE CLERK _____</p>		<p>88. SIGNATURE OF HISTORIC PRESERVATION CLERK _____</p>	
<p>89. SIGNATURE OF MONUMENTS CLERK _____</p>		<p>90. SIGNATURE OF NATIONAL PARKS CLERK _____</p>	
<p>91. SIGNATURE OF NATIONAL MONUMENTS CLERK _____</p>		<p>92. SIGNATURE OF NATIONAL HISTORIC LANDS CLERK _____</p>	
<p>93. SIGNATURE OF NATIONAL HISTORIC MONUMENTS CLERK _____</p>		<p>94. SIGNATURE OF NATIONAL HISTORIC PRESERVATION CLERK _____</p>	
<p>95. SIGNATURE OF NATIONAL HISTORIC LANDS CLERK _____</p>		<p>96. SIGNATURE OF NATIONAL HISTORIC MONUMENTS CLERK _____</p>	
<p>97. SIGNATURE OF NATIONAL HISTORIC PRESERVATION CLERK _____</p>		<p>98. SIGNATURE OF NATIONAL HISTORIC LANDS CLERK _____</p>	
<p>99. SIGNATURE OF NATIONAL HISTORIC MONUMENTS CLERK _____</p>		<p>100. SIGNATURE OF NATIONAL HISTORIC PRESERVATION CLERK _____</p>	

1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7048

CERTIFICATE OF DEATH

07031

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY Berks County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenwood		c. LENGTH OF STAY IN 1b 7 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5707 Springfield Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle M. Last MOYER		4. DATE OF DEATH Month June Day 22 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1875
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 0 Days 22 Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Penna.	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Jacob Murray		14. MOTHER'S MAIDEN NAME Harriett Wickline	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT George A. Pleam Son-in-law		Address Same as Item #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Glomerulo Nephritis DUE TO (c) indefinite			INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-sclerotic heart disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Nov , 19 57 , to June 22 , 19 58 , that I last saw the deceased alive on June 22 , 19 58 , and that death occurred at 8:30 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert G. Taylor		ADDRESS (Street, city or town, state) Washington Clinic, Washington 15 Dc	
PHYSICIAN'S NAME (Type) ROBERT G. TAYLOR		DATE SIGNED 6-22-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit	22b. DATE THEREOF 6-23-58	22c. NAME OF CEMETERY OR CREMATORY St. John's Cem.	22d. LOCATION (City, town, or county) (State) Berks County, Penna.
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		24. REG'D BY REGISTRAR JUN 25 58	
ADDRESS Bethesda, Md.		24b. REGISTRAR'S SIGNATURE W. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES			

7049

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5601 Wyngate Drive				c. LENGTH OF STAY IN 1b yes.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 5601 Wyngate Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) SARAH JEANNETTE MURPHY First Middle Last				4. DATE OF DEATH JUNE 25 1958 Month Day Year			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 15, 1885	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME James W Higgs				14. MOTHER'S MAIDEN NAME Alice Welch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Joseph A Murphy		Address Bethesda Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL APOPLEXY 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 1 WEEK	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X DIABETES MELLITUS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SEPT 20, 1957 to JUNE 25, 1958 , that I last saw the deceased alive on JUNE 24, 1958 , and that death occurred at 7:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. C. Kirchner M.D.				DATE SIGNED 6480-N.H. 002-			
PHYSICIAN'S NAME (Type) R.C. KIRCHNER M.D. Takoma Park, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/27/58		22c. NAME OF CEMETERY OR CREMATORY xxxxxxx Church of ascension		22d. LOCATION (City, town, or county) (State) Bowie, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE F Gasch's Sons Hyattsville, Maryland.				24a. REC'D BY REGISTRAR DATE JUN 30 '58		24b. REGISTRAR'S SIGNATURE One! Smith	

CERTIFICATE OF DEATH

DECEASED NAME JAMES A. HENRY		SEX Male	
AGE 35		DATE OF BIRTH Dec 15, 1922	
PLACE OF BIRTH Baltimore, Md.		RACE White	
OCCUPATION Clerk		CAUSE OF DEATH Myocardial Infarction	
PLACE OF DEATH 5001 Wyngate Drive		DATE OF DEATH Dec 15, 1958	
TIME OF DEATH 10:15 AM		SIGNATURE OF DECEASED (None)	
SIGNATURE OF WITNESSES (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF CORONER (None)		SIGNATURE OF REGISTRAR (None)	
SIGNATURE OF CLERK (None)		SIGNATURE OF CHURCH OF ASSOCIATION (None)	
SIGNATURE OF MINISTER (None)		SIGNATURE OF BURIAL SOCIETY (None)	
SIGNATURE OF FUNERAL HOME (None)		SIGNATURE OF CEMETERY (None)	
SIGNATURE OF HEALTH DEPARTMENT (None)		SIGNATURE OF STATE DEPARTMENT OF HEALTH (None)	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 8 & 9, Form G-231 7/10/58.cac.
6953
CERTIFICATE OF DEATH

07033

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park D.D.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>705 Ritchie Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Emma Louise Naecker</u>		4. DATE OF DEATH <u>6 - 19 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1884 FEBRUARY 9, 1884</u>
9. AGE (In years lost birthday) <u>74 2/5</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
13. FATHER'S NAME <u>JOHN BAILEY</u>		14. MOTHER'S MAIDEN NAME <u>XXX MARY EMMA HARDESTY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Son-in-law</u> Address <u>Hamer J. Booth - 7019 Georgia Ave - DC</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Super Chronic Cardiac degeneration</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 19, 1958</u> to <u>June 19, 1958</u> that I last saw the deceased alive on <u>June 19, 1958</u> , and that death occurred at <u>12014</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph F. Patten</u> M.D.		DATE SIGNED <u>8641 Colverville Rd.</u>	
PHYSICIAN'S NAME (Type) <u>RALPH F. PATTEN</u>		ADDRESS (Street, city or town, state) <u>8641 Colverville Rd.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/21/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD</u>		24a. REC'D BY REGISTRAR <u>JUN 20 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arbeach</u>			

CERTIFICATE OF DEATH

1955

FILE NO.

DATE OF DEATH

PLACE

DECEASED

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

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DEPARTMENT OF HEALTH

BALTIMORE, MD

1955

FILE NO.

DATE OF DEATH

PLACE OF DEATH

7050

CERTIFICATE OF DEATH

Reg. Dist. No. 07034

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
1. NAME OF DECEASED (Type or print) First Middle Last <u>Amanda Carolyn Nelson</u>				4. DATE OF DEATH Month Day Year <u>June 14 1958</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 16, 1884</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Calumet Mich.</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Peter Moen</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Helen Woodworth</u>		Address <u>2312 Seminary Rd. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis, Right coronary artery</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis, severe</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hr.</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb</u> , 1957, to <u>14 June</u> , 1958, that I last saw the deceased alive on <u>14 June</u> , 1958, and that death occurred at <u>1:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Merton L. White</u>				ADDRESS (Street, city or town, state) <u>11134 Georgia Ave N.W. D.C.</u>			
DATE SIGNED <u>14 June 58</u>							
PHYSICIAN'S NAME (Type) <u>MERTON L. WHITE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 17, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Shetterly</u>				ADDRESS <u>254 Canale St. N.W. Washington 12, D.C.</u>		24a. REC'D BY REGISTRAR <u>—</u>	
				DATE <u>JUN 17 1958</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6962

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 215 Harrison Street		d. STREET ADDRESS 215 Harrison Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WALTER Middle STANLEY Last NICEWARNER		4. DATE OF DEATH Month June Day 23 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1896
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 1 Days 17 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) W. Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Nicewarner		14. MOTHER'S MAIDEN NAME Malinda Ott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-20-0282	
17. INFORMANT Mrs Nellie Nicewarner-Item# 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIAL HYPERTENSION DUE TO (c) GENERALIZED ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS TEN YEARS TEN YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH 11, 1958 , to JUNE 23, 1958 , that I last saw the deceased alive on JUNE 21, 1958 , and that death occurred at 9:15 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon S. Rosenberger		DATE SIGNED June 23, 1958	
PHYSICIAN'S NAME (Type) Gordon S. Rosenberger		ADDRESS (Street, city or town, state) 26 N. Summit Ave Gaithersburg, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/26/58	22c. NAME OF CEMETERY OR CREMATORY Rockville	22d. LOCATION (City, town, or county) (State) Rockville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR JUN 25 1958	
		24b. REGISTRAR'S SIGNATURE Aw. K. Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1932

NAME OF DECEASED Robert A. Humphrey-Betneda, Maryland		DATE OF BIRTH 07/20/32		PLACE OF BIRTH Rockville, Maryland	
RESIDENCE Rockville, Maryland		DATE OF DEATH 01/20/33		PLACE OF DEATH Rockville, Maryland	
OCCUPATION None		CAUSE OF DEATH None		MANNER OF DEATH None	
EDUCATION None		RELIGION None		MARITAL STATUS None	
PREVIOUS ILLNESS None		TREATMENT None		HISTORICAL RECORD None	
FAMILY HISTORY None		SOCIAL HISTORY None		PHYSICAL HISTORY None	
MENTAL HISTORY None		PATHOLOGICAL HISTORY None		LABORATORY HISTORY None	
RADIOLOGICAL HISTORY None		THERAPEUTIC HISTORY None		PROGNOSIS None	
FOLLOW-UP HISTORY None		DEATH CERTIFICATE None		BURIAL RECORD None	
FUNERAL RECORD None		CEREMONY RECORD None		CLOSING RECORD None	
REMARKS None		SIGNATURE None		DATE None	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07036

7051

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 704 McNeill Road		d. STREET ADDRESS 1 704 McNeill Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HOWARD Middle W. Last NIPLE		4. DATE OF DEATH Month JUNE Day 8 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/24/74
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 8 Days 19 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MOTORMAN (retired)		10b. KIND OF BUSINESS OR INDUSTRY Capital Transit Co.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HEZAKIAH NIPLE		14. MOTHER'S MAIDEN NAME JANE WILHIDE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 577-05-7825	
17. INFORMANT Mrs. Elsie M. Burton, 704 McNeill Rd. Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation DUE TO 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO ? (c) Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ? INTERVAL BETWEEN ONSET AND DEATH about 56 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that attended the deceased from 19 53 to 8 June 19 58 , that I last saw the deceased alive on 6 June 19 58 , and that death occurred at 5:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9006 Coleraine Rd, Silver Spring, Md. DATE SIGNED 6/11/58			
ACTUAL SIGNATURE William D. Aud M.D.		PHYSICIAN'S NAME (Type) WILLIAM D. AUD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/10/58	
22c. NAME OF CEMETERY OR CREMATORY UNION CEMETERY		22d. LOCATION (City, town, or county) (State) BURTONSVILLE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE JUN 11 1958		24b. REGISTRAR'S SIGNATURE Arthur	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7052

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md.</i> b. COUNTY <i>Mont. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda, Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Box 56 - Sellman, Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>Sellman, Md.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Lawrence Claude Onley</i>		4. DATE OF DEATH Month Day Year <i>June 2, 1958</i>	
5. SEX <i>m</i>	6. COLOR OR RACE <i>colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 19, 1896</i>
9. AGE (In years last birthday) <i>61</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Local minister</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Sellman, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Henry T. Onley</i>		14. MOTHER'S MAIDEN NAME <i>Mary Fisher</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>Chas. E. Onley - Box 58 - Md.</i>	
17. INFORMANT Address <i>Sellman, Md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive Failure</i> <i>433.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiac Arrest</i> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized Carcinomatosis Primary Undet.</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 24, 1958</i> to <i>June 2, 1958</i> , that I last saw the deceased alive on <i>June 2, 1958</i> , and that death occurred at <i>7:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John P. Haberlin</i> M.D.		ADDRESS (Street, city or town, state) <i>927 Pershing W. Silver Spring, Md.</i>	
PHYSICIAN'S NAME (Type) <i>John P. Haberlin</i>		DATE SIGNED <i>6-2-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>5/1/58</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion,</i>		22d. LOCATION (City, town, or county) (State) <i>Barnesville, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Surden</i> ADDRESS <i>Rockville, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 9 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>W. E. ...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1002

11

NAME OF DECEASED MARY ANN BROWN		SEX F		AGE 65	
PLACE OF BIRTH BALTIMORE, MARYLAND		DATE OF BIRTH JAN 15 1880		PLACE OF DEATH BALTIMORE, MARYLAND	
OCCUPATION HOUSEWIFE		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
DATE OF DEATH DEC 10 1945		TIME OF DEATH 11:00 AM		PLACE OF INTERMENT GREENWICH CEMETERY	
SIGNATURE OF PHYSICIAN J. H. BROWN		SIGNATURE OF CORONER J. H. BROWN		SIGNATURE OF WITNESSES J. H. BROWN, MARY ANN BROWN	
CERTIFICATE OF DEATH I, J. H. BROWN, M.D., hereby certify that the above named person died on the 10th day of December, 1945, at the age of 65 years, from the cause stated above.		I, J. H. BROWN, Coroner, hereby certify that the above named person died on the 10th day of December, 1945, at the age of 65 years, from the cause stated above.		I, J. H. BROWN, Witness, hereby certify that the above named person died on the 10th day of December, 1945, at the age of 65 years, from the cause stated above.	

This certificate is a true and correct copy of the original as filed in the office of the Registrar of Births and Deaths, Baltimore, Maryland, on the 10th day of December, 1945.
 J. H. BROWN, Registrar of Births and Deaths, Baltimore, Maryland.
 I, J. H. BROWN, Coroner, hereby certify that the above named person died on the 10th day of December, 1945, at the age of 65 years, from the cause stated above.
 I, J. H. BROWN, Witness, hereby certify that the above named person died on the 10th day of December, 1945, at the age of 65 years, from the cause stated above.

may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7053

CERTIFICATE OF DEATH

Reg. Dist. No.

07038

1. PLACE OF DEATH o. COUNTY Montg MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown	c. LENGTH OF STAY IN 1b 2yr 9Mo	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown Washington D.C. 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Marylander Rest Home		d. STREET ADDRESS 2833 McGill Terr, N.W.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Pearl Middle A. Last Overman		4. DATE OF DEATH Month June Day 10 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12-1867
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months 9 Days 10 Hours 19 Min.	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home Work	11. BIRTHPLACE (State or foreign country) Clinton . Iowa
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Henry Arkman	
14. MOTHER'S MAIDEN NAME Anna M. Atchinson,		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Records, The Marylander, Germantown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 yrs.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 5 , 19 56 , to June 10 , 19 58 , that I last saw the deceased alive on June 9 , 19 58 , and that death occurred at M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James P. Kerr		ADDRESS (Street, city or town, state) Gaithersburg Md.	
PHYSICIAN'S NAME (Type) James P. Kerr		DATE SIGNED 6/10/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 6-10-58	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	22d. LOCATION (City, town, or county) (State) Bladensburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.		ADDRESS Gaithersburg. Md.	
24a. REC'D BY REGISTRAR JUN 11 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

7054

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 90 LeDeau Gardens Rest Home				e. STREET ADDRESS 17 Takoma Park 7111 Woodland Ave.			
3. NAME OF DECEASED (Type or print) First Fannie Middle V. Last Pack				4. DATE OF DEATH Month June Day 27 Year 19 58			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/17/1884	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George S. Burton				14. MOTHER'S MAIDEN NAME Mary S. Utz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Walter B. Park- 7111 Woodland Ave.		Address Takoma Pk. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 200.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Retinulum cell sarcoma of abdomen DUE TO (c) 1 yr							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from July 10, 1957 , to June 27, 1958 , that I last saw the deceased alive on June 14, 1958 , and that death occurred at 5:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 401 Kennedy St. N.W. Wash. D.C. DATE SIGNED June 27, 1958							
ACTUAL SIGNATURE M. F. OTTMAN		M.D. Wash. D.C.					
PHYSICIAN'S NAME (Type) M. F. OTTMAN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/30/58	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.			
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Fines Co. Washington, D.C.				24a. REC'D BY REGISTRAR DATE JUN 30 '58		24b. REGISTRAR'S SIGNATURE W. B. Beach	

CERTIFICATE OF DEATH

1. PLACE OF DEATH A. HOME		2. SEX Male	
3. AGE 45		4. RACE White	
5. OCCUPATION Teacher		6. MARITAL STATUS Married	
7. DATE OF DEATH April 10, 1954		8. TIME OF DEATH 10:30 AM	
9. CAUSE OF DEATH Myocardial Infarction		10. PLACE OF BIRTH Baltimore, Md.	
11. DATE OF BIRTH March 15, 1909		12. SEX Male	
13. RACE White		14. MARITAL STATUS Married	
15. OCCUPATION Teacher		16. DATE OF DEATH April 10, 1954	
17. TIME OF DEATH 10:30 AM		18. PLACE OF BIRTH Baltimore, Md.	
19. SEX Male		20. RACE White	
21. MARITAL STATUS Married		22. OCCUPATION Teacher	
23. DATE OF DEATH April 10, 1954		24. TIME OF DEATH 10:30 AM	
25. PLACE OF BIRTH Baltimore, Md.		26. SEX Male	
27. RACE White		28. MARITAL STATUS Married	
29. OCCUPATION Teacher		30. DATE OF DEATH April 10, 1954	
31. TIME OF DEATH 10:30 AM		32. PLACE OF BIRTH Baltimore, Md.	
33. SEX Male		34. RACE White	
35. MARITAL STATUS Married		36. OCCUPATION Teacher	
37. DATE OF DEATH April 10, 1954		38. TIME OF DEATH 10:30 AM	
39. PLACE OF BIRTH Baltimore, Md.		40. SEX Male	
41. RACE White		42. MARITAL STATUS Married	
43. OCCUPATION Teacher		44. DATE OF DEATH April 10, 1954	
45. TIME OF DEATH 10:30 AM		46. PLACE OF BIRTH Baltimore, Md.	
47. SEX Male		48. RACE White	
49. MARITAL STATUS Married		50. OCCUPATION Teacher	
51. DATE OF DEATH April 10, 1954		52. TIME OF DEATH 10:30 AM	
53. PLACE OF BIRTH Baltimore, Md.		54. SEX Male	
55. RACE White		56. MARITAL STATUS Married	
57. OCCUPATION Teacher		58. DATE OF DEATH April 10, 1954	
59. TIME OF DEATH 10:30 AM		60. PLACE OF BIRTH Baltimore, Md.	
61. SEX Male		62. RACE White	
63. MARITAL STATUS Married		64. OCCUPATION Teacher	
65. DATE OF DEATH April 10, 1954		66. TIME OF DEATH 10:30 AM	
67. PLACE OF BIRTH Baltimore, Md.		68. SEX Male	
69. RACE White		70. MARITAL STATUS Married	
71. OCCUPATION Teacher		72. DATE OF DEATH April 10, 1954	
73. TIME OF DEATH 10:30 AM		74. PLACE OF BIRTH Baltimore, Md.	
75. SEX Male		76. RACE White	
77. MARITAL STATUS Married		78. OCCUPATION Teacher	
79. DATE OF DEATH April 10, 1954		80. TIME OF DEATH 10:30 AM	
81. PLACE OF BIRTH Baltimore, Md.		82. SEX Male	
83. RACE White		84. MARITAL STATUS Married	
85. OCCUPATION Teacher		86. DATE OF DEATH April 10, 1954	
87. TIME OF DEATH 10:30 AM		88. PLACE OF BIRTH Baltimore, Md.	
89. SEX Male		90. RACE White	
91. MARITAL STATUS Married		92. OCCUPATION Teacher	
93. DATE OF DEATH April 10, 1954		94. TIME OF DEATH 10:30 AM	
95. PLACE OF BIRTH Baltimore, Md.		96. SEX Male	
97. RACE White		98. MARITAL STATUS Married	
99. OCCUPATION Teacher		100. DATE OF DEATH April 10, 1954	
101. TIME OF DEATH 10:30 AM		102. PLACE OF BIRTH Baltimore, Md.	
103. SEX Male		104. RACE White	
105. MARITAL STATUS Married		106. OCCUPATION Teacher	
107. DATE OF DEATH April 10, 1954		108. TIME OF DEATH 10:30 AM	
109. PLACE OF BIRTH Baltimore, Md.		110. SEX Male	
111. RACE White		112. MARITAL STATUS Married	
113. OCCUPATION Teacher		114. DATE OF DEATH April 10, 1954	
115. TIME OF DEATH 10:30 AM		116. PLACE OF BIRTH Baltimore, Md.	
117. SEX Male		118. RACE White	
119. MARITAL STATUS Married		120. OCCUPATION Teacher	
121. DATE OF DEATH April 10, 1954		122. TIME OF DEATH 10:30 AM	
123. PLACE OF BIRTH Baltimore, Md.		124. SEX Male	
125. RACE White		126. MARITAL STATUS Married	
127. OCCUPATION Teacher		128. DATE OF DEATH April 10, 1954	
129. TIME OF DEATH 10:30 AM		130. PLACE OF BIRTH Baltimore, Md.	
131. SEX Male		132. RACE White	
133. MARITAL STATUS Married		134. OCCUPATION Teacher	
135. DATE OF DEATH April 10, 1954		136. TIME OF DEATH 10:30 AM	
137. PLACE OF BIRTH Baltimore, Md.		138. SEX Male	
139. RACE White		140. MARITAL STATUS Married	
141. OCCUPATION Teacher		142. DATE OF DEATH April 10, 1954	
143. TIME OF DEATH 10:30 AM		144. PLACE OF BIRTH Baltimore, Md.	
145. SEX Male		146. RACE White	
147. MARITAL STATUS Married		148. OCCUPATION Teacher	
149. DATE OF DEATH April 10, 1954		150. TIME OF DEATH 10:30 AM	
151. PLACE OF BIRTH Baltimore, Md.		152. SEX Male	
153. RACE White		154. MARITAL STATUS Married	
155. OCCUPATION Teacher		156. DATE OF DEATH April 10, 1954	
157. TIME OF DEATH 10:30 AM		158. PLACE OF BIRTH Baltimore, Md.	
159. SEX Male		160. RACE White	
161. MARITAL STATUS Married		162. OCCUPATION Teacher	
163. DATE OF DEATH April 10, 1954		164. TIME OF DEATH 10:30 AM	
165. PLACE OF BIRTH Baltimore, Md.		166. SEX Male	
167. RACE White		168. MARITAL STATUS Married	
169. OCCUPATION Teacher		170. DATE OF DEATH April 10, 1954	
171. TIME OF DEATH 10:30 AM		172. PLACE OF BIRTH Baltimore, Md.	
173. SEX Male		174. RACE White	
175. MARITAL STATUS Married		176. OCCUPATION Teacher	
177. DATE OF DEATH April 10, 1954		178. TIME OF DEATH 10:30 AM	
179. PLACE OF BIRTH Baltimore, Md.		180. SEX Male	
181. RACE White		182. MARITAL STATUS Married	
183. OCCUPATION Teacher		184. DATE OF DEATH April 10, 1954	
185. TIME OF DEATH 10:30 AM		186. PLACE OF BIRTH Baltimore, Md.	
187. SEX Male		188. RACE White	
189. MARITAL STATUS Married		190. OCCUPATION Teacher	
191. DATE OF DEATH April 10, 1954		192. TIME OF DEATH 10:30 AM	
193. PLACE OF BIRTH Baltimore, Md.		194. SEX Male	
195. RACE White		196. MARITAL STATUS Married	
197. OCCUPATION Teacher		198. DATE OF DEATH April 10, 1954	
199. TIME OF DEATH 10:30 AM		200. PLACE OF BIRTH Baltimore, Md.	

THE J. HARRIS CO. BALTIMORE, MD. 4/30/54
Baltimore, Md. 4/30/54
Baltimore, Md. 4/30/54

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7055

CERTIFICATE OF DEATH

Reg. Dist. No. 07040

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN TB <u>5 days, 2 hrs.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> <u>26</u>				d. STREET ADDRESS <u>1118 Edmonston Drive</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Paterson</u> Last <u>Paterson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 29, 1886</u>	
9. AGE (In years lost birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Motoring Art. dir.</u>			
11. BIRTHPLACE (State or foreign country) <u>Edinburgh, Scotland</u>				12. CITIZEN OF WHAT COUNTRY? <u>British</u>			
13. FATHER'S NAME <u>JAMES PATERSON</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Garrioch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>British</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Hospital Record</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIAL SCLEROSIS</u> DUE TO <u>10 YEARS</u> (c) <u>ARTERIAL HYPERTENSION</u> <u>10 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u> </u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>MAY 25, 1958</u> , to <u>JUNE 3, 1958</u> , that I last saw the deceased alive on <u>JUNE 2, 1958</u> , and that death occurred at <u>1 P. M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gordon S. Rosenberger</u>				ADDRESS (Street, city or town, state) <u>26 A Summit Ave. Rockville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Gordon S. Rosenberger, M.D.</u>				DATE SIGNED <u>3 June 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>			
24a. REC'D BY REGISTRAR DATE <u>JUN 4 '58</u>				24b. REGISTRAR'S SIGNATURE <u>Alb. Leach</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]	
DATE OF BIRTH [Faint text]		PLACE OF BIRTH [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
CITY AND COUNTY [Faint text]		STATE [Faint text]	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD.
 IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILED.
 IN WITNESS WHEREOF, I HAVE HEREUNTO SET MY HAND AND SEAL OF OFFICE, THIS [Faint text] DAY OF [Faint text] 19[Faint text].

7056

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Cook			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 19 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Dorothy Middle Lydia Last Paulson				4. DATE OF DEATH Month June Day 8 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 11, 1911	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months 1 Days 27		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Librarian				10b. KIND OF BUSINESS OR INDUSTRY Library		11. BIRTHPLACE (State or foreign country) Wisconsin	
13. FATHER'S NAME Nils Brue				14. MOTHER'S MAIDEN NAME Anna Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 324-30-6404		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 173X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Broncho-pneumonia (c) CHORIOCARCINOMA - metastatic to VAGINA, URINARY BLADDER, and RIGHT UTERUS INTERVAL BETWEEN ONSET AND DEATH 7-1 day (3 hrs) several days 9 mos.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 20 , 19 58 , to June 8 , 19 58 , that I last saw the deceased alive on June 8 , 19 58 , and that death occurred at 4:30 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Kahn M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 6/9/58			
PHYSICIAN'S NAME (Type) S. Kahn, M. D.				The National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		22b. DATE THEREOF 6/10/58		22c. NAME OF CEMETERY OR CREMATORY Norway Grove Cemetery		22d. LOCATION (City, town, or county) (State) DeForest, Wisconsin	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUN 10 '58	
				24b. REGISTRAR'S SIGNATURE W. J. Leach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45 years</u></p>		<p>4. Date of death: <u>Jan 11, 1911</u></p>	
<p>5. Place of death: <u>Home</u></p>		<p>6. Cause of death: <u>Heart Disease</u></p>	
<p>7. Signature of attending physician: <u>Dr. J. A. Smith</u></p>		<p>8. Signature of registrar: <u>W. B. Jones</u></p>	
<p>9. Date of registration: <u>Jan 12, 1911</u></p>		<p>10. Place of registration: <u>Boston</u></p>	
<p>11. Name of informant: <u>John Doe</u></p>		<p>12. Address of informant: <u>123 Main St.</u></p>	
<p>13. Signature of informant: <u>John Doe</u></p>		<p>14. Date of statement: <u>Jan 11, 1911</u></p>	
<p>15. Signature of registrar: <u>W. B. Jones</u></p>		<p>16. Date of registration: <u>Jan 12, 1911</u></p>	
<p>17. Signature of registrar: <u>W. B. Jones</u></p>		<p>18. Date of registration: <u>Jan 12, 1911</u></p>	
<p>19. Signature of registrar: <u>W. B. Jones</u></p>		<p>20. Date of registration: <u>Jan 12, 1911</u></p>	
<p>21. Signature of registrar: <u>W. B. Jones</u></p>		<p>22. Date of registration: <u>Jan 12, 1911</u></p>	
<p>23. Signature of registrar: <u>W. B. Jones</u></p>		<p>24. Date of registration: <u>Jan 12, 1911</u></p>	
<p>25. Signature of registrar: <u>W. B. Jones</u></p>		<p>26. Date of registration: <u>Jan 12, 1911</u></p>	
<p>27. Signature of registrar: <u>W. B. Jones</u></p>		<p>28. Date of registration: <u>Jan 12, 1911</u></p>	
<p>29. Signature of registrar: <u>W. B. Jones</u></p>		<p>30. Date of registration: <u>Jan 12, 1911</u></p>	
<p>31. Signature of registrar: <u>W. B. Jones</u></p>		<p>32. Date of registration: <u>Jan 12, 1911</u></p>	
<p>33. Signature of registrar: <u>W. B. Jones</u></p>		<p>34. Date of registration: <u>Jan 12, 1911</u></p>	
<p>35. Signature of registrar: <u>W. B. Jones</u></p>		<p>36. Date of registration: <u>Jan 12, 1911</u></p>	
<p>37. Signature of registrar: <u>W. B. Jones</u></p>		<p>38. Date of registration: <u>Jan 12, 1911</u></p>	
<p>39. Signature of registrar: <u>W. B. Jones</u></p>		<p>40. Date of registration: <u>Jan 12, 1911</u></p>	
<p>41. Signature of registrar: <u>W. B. Jones</u></p>		<p>42. Date of registration: <u>Jan 12, 1911</u></p>	
<p>43. Signature of registrar: <u>W. B. Jones</u></p>		<p>44. Date of registration: <u>Jan 12, 1911</u></p>	
<p>45. Signature of registrar: <u>W. B. Jones</u></p>		<p>46. Date of registration: <u>Jan 12, 1911</u></p>	
<p>47. Signature of registrar: <u>W. B. Jones</u></p>		<p>48. Date of registration: <u>Jan 12, 1911</u></p>	
<p>49. Signature of registrar: <u>W. B. Jones</u></p>		<p>50. Date of registration: <u>Jan 12, 1911</u></p>	
<p>51. Signature of registrar: <u>W. B. Jones</u></p>		<p>52. Date of registration: <u>Jan 12, 1911</u></p>	
<p>53. Signature of registrar: <u>W. B. Jones</u></p>		<p>54. Date of registration: <u>Jan 12, 1911</u></p>	
<p>55. Signature of registrar: <u>W. B. Jones</u></p>		<p>56. Date of registration: <u>Jan 12, 1911</u></p>	
<p>57. Signature of registrar: <u>W. B. Jones</u></p>		<p>58. Date of registration: <u>Jan 12, 1911</u></p>	
<p>59. Signature of registrar: <u>W. B. Jones</u></p>		<p>60. Date of registration: <u>Jan 12, 1911</u></p>	
<p>61. Signature of registrar: <u>W. B. Jones</u></p>		<p>62. Date of registration: <u>Jan 12, 1911</u></p>	
<p>63. Signature of registrar: <u>W. B. Jones</u></p>		<p>64. Date of registration: <u>Jan 12, 1911</u></p>	
<p>65. Signature of registrar: <u>W. B. Jones</u></p>		<p>66. Date of registration: <u>Jan 12, 1911</u></p>	
<p>67. Signature of registrar: <u>W. B. Jones</u></p>		<p>68. Date of registration: <u>Jan 12, 1911</u></p>	
<p>69. Signature of registrar: <u>W. B. Jones</u></p>		<p>70. Date of registration: <u>Jan 12, 1911</u></p>	
<p>71. Signature of registrar: <u>W. B. Jones</u></p>		<p>72. Date of registration: <u>Jan 12, 1911</u></p>	
<p>73. Signature of registrar: <u>W. B. Jones</u></p>		<p>74. Date of registration: <u>Jan 12, 1911</u></p>	
<p>75. Signature of registrar: <u>W. B. Jones</u></p>		<p>76. Date of registration: <u>Jan 12, 1911</u></p>	
<p>77. Signature of registrar: <u>W. B. Jones</u></p>		<p>78. Date of registration: <u>Jan 12, 1911</u></p>	
<p>79. Signature of registrar: <u>W. B. Jones</u></p>		<p>80. Date of registration: <u>Jan 12, 1911</u></p>	
<p>81. Signature of registrar: <u>W. B. Jones</u></p>		<p>82. Date of registration: <u>Jan 12, 1911</u></p>	
<p>83. Signature of registrar: <u>W. B. Jones</u></p>		<p>84. Date of registration: <u>Jan 12, 1911</u></p>	
<p>85. Signature of registrar: <u>W. B. Jones</u></p>		<p>86. Date of registration: <u>Jan 12, 1911</u></p>	
<p>87. Signature of registrar: <u>W. B. Jones</u></p>		<p>88. Date of registration: <u>Jan 12, 1911</u></p>	
<p>89. Signature of registrar: <u>W. B. Jones</u></p>		<p>90. Date of registration: <u>Jan 12, 1911</u></p>	
<p>91. Signature of registrar: <u>W. B. Jones</u></p>		<p>92. Date of registration: <u>Jan 12, 1911</u></p>	
<p>93. Signature of registrar: <u>W. B. Jones</u></p>		<p>94. Date of registration: <u>Jan 12, 1911</u></p>	
<p>95. Signature of registrar: <u>W. B. Jones</u></p>		<p>96. Date of registration: <u>Jan 12, 1911</u></p>	
<p>97. Signature of registrar: <u>W. B. Jones</u></p>		<p>98. Date of registration: <u>Jan 12, 1911</u></p>	
<p>99. Signature of registrar: <u>W. B. Jones</u></p>		<p>100. Date of registration: <u>Jan 12, 1911</u></p>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A1SME
5M 2/57

Items 18-21 Film 231 7-7-58 AMS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7057 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07042

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. Co. General Hospital		e. STREET ADDRESS Claggettsville	
3. NAME OF DECEASED (Type or print) Mary Catherine Peach		4. DATE OF DEATH June 21, 1958	
5. SEX female	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/17/1918
9. AGE (in years last birthday) 39 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arther Peach		14. MOTHER'S MAIDEN NAME Elizebeth Bowie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-30-5903	
17. INFORMANT William W. Thomas, Monrovia, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Alcohol & Barbiturate poisoning 9771.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lab. reports 0.18% ethyl alcohol and 1.25 mg. % barbiturates Reported to have taken an overdose of sleeping pills		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6/22/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 24, 1958	
22c. NAME OF CEMETERY OR CREMATORY Simpson Chapel		22d. LOCATION (City, town, or county) (State) New Market, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas L. Moleworth		ADDRESS Damascus, Md.	
24a. REC'D BY REGISTRAR BUN 25 '58		24b. REGISTRAR'S SIGNATURE Chas L. Moleworth	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. TIME OF DEATH</p>		<p>10. PLACE OF DEATH</p>		<p>11. SIGNATURE OF EXAMINER</p>		<p>12. SIGNATURE OF WITNESS</p>	
<p>13. SIGNATURE OF DECEASED</p>		<p>14. SIGNATURE OF NEXT OF KIN</p>		<p>15. SIGNATURE OF PHYSICIAN</p>		<p>16. SIGNATURE OF JURY</p>	
<p>17. SIGNATURE OF CORONER</p>		<p>18. SIGNATURE OF JUDGE</p>		<p>19. SIGNATURE OF CLERK</p>		<p>20. SIGNATURE OF RECORDS</p>	

6954

CERTIFICATE OF DEATH

07043

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sen. Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>nmw</u> Last <u>Parkins</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>23</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-15-94</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Russia</u>				12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>			
13. FATHER'S NAME <u>Benjamin Stein</u>				14. MOTHER'S MAIDEN NAME <u>Naomi Chalip</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>medical records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>myocardial infarction</u> DUE TO (c) <u>coronary sclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>1 day</u> <u>6 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>54</u> , to <u>June</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 23</u> , 19 <u>58</u> , and that death occurred at <u>2:45 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sam C. Weiner</u>				M.D. <u>100 Longfellow St. N.W. Wash. DC</u>		DATE SIGNED <u>6/23/58</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HAR NEBO Cem.</u>		22d. LOCATION (City, town, or County) (State) <u>PHILA. PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>				ADDRESS <u>4217 9th NW</u>		24a. REC'D BY REGISTRAR <u>25 '58</u> DATE	
				24b. REGISTRAR'S SIGNATURE <u>Rehman</u>			

MEDICAL CERTIFICATION

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7058

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>6hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 13203 Okinawa Ave.</u>			
				d. STREET ADDRESS <u>1 Rockville, Md</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Diana</u> Middle <u>S</u> Last <u>Petrey</u>				4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 25 1914</u>	
9. AGE (In years lost birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>7</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>Augustus Fitch O'Brien</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Coleman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u>226-26-3186</u>		17. INFORMANT <u>Mrs. Marshal Petrey</u> Address <u>Husband--same as 2d</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic Coma</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>10 years +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>P. P. Andrews</u> M.D. <u>4201 Fessenden St NW</u> <u>6-2-58</u> PHYSICIAN'S NAME (Type) <u>P. P. Andrews</u> <u>Washington D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>JUN 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Reese</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2008

NAME OF DECEASED		DATE OF DEATH	
JAMES H. SMITH		JAN 15 1908	
AGE		SEX	
65		M	
PLACE OF BIRTH		DATE OF BIRTH	
NEW YORK		JAN 15 1843	
EDUCATION		OCCUPATION	
HIGH SCHOOL		FARMER	
MARRIED		SINGLE	
YES		NO	
DATE OF MARRIAGE		PLACE OF MARRIAGE	
JAN 15 1865		NEW YORK	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
DETAILS OF DISEASE		DETAILS OF MANNER	
HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH	
JAN 15 1908		NEW YORK	
DATE OF INTERMENT		PLACE OF INTERMENT	
JAN 15 1908		NEW YORK	
NAME OF FUNERAL HOME		NAME OF MINISTER	
JAMES H. SMITH		JAMES H. SMITH	
DATE OF DEATH		PLACE OF DEATH	
JAN 15 1908		NEW YORK	
DATE OF INTERMENT		PLACE OF INTERMENT	
JAN 15 1908		NEW YORK	
NAME OF FUNERAL HOME		NAME OF MINISTER	
JAMES H. SMITH		JAMES H. SMITH	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF SOCIAL SERVICES.

CERTIFICATE OF DEATH

Reg. Dist. No.

7059

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 20			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1201 Trenton Place, S.E.			
3. NAME OF DECEASED (Type or print) First Michael Middle William Last Peyton				4. DATE OF DEATH Month June Day 12 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 24 December 1953	
9. AGE (In years last birthday) 4		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		IF UNDER 24 HRS. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child (none)				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Donald F. Peyton				14. MOTHER'S MAIDEN NAME Julia L. Cunningham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 754.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rt. ventricular failure DUE TO (c) Ventricular septal defect, status post-operative congenital PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 12 hrs INTERVAL BETWEEN ONSET AND DEATH 35 min							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June, 8 , 19 58 , to June, 12 , 19 58 , that I last saw the deceased alive on June, 12 , 19 58 , and that death occurred at 5:00A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE James A. McFarland M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 6/12/58			
PHYSICIAN'S NAME (Type) James A. McFarland, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)	
Buried		6-14-58		Cedar Hill		Seatons md	
23. FUNERAL DIRECTOR'S SIGNATURE Sumner Bros.				ADDRESS 1661 - Good Hope Rd SE Wash. DC		24a. REC'D BY REGISTRAR JUN 16 '58	
				24b. REGISTRAR'S SIGNATURE W. H. Beach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7060

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9922 Georgia Ave - Apt 2</u>			d. STREET ADDRESS <u>9922 Georgia Ave - Apt 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Joseph Pies</u>			4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1958</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-26-88</u>		9. AGE (In years last birthday) <u>70</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gardner</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Joseph Pies</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Ralph Plesner</u> Address <u>6207 Wagner La Wash DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Bloechant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Bloechant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>6-5-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/9/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

07046

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS
DEPARTMENT OF HEALTH

10

DATE OF DEATH
1941

DECEASED

DATE OF BIRTH
1941

PLACE OF BIRTH

AGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7061

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 Film 230 6-23-58 et

07047

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (When deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring West Dundee 51X-3V	
c. LENGTH OF STAY IN 1b 8 mos.		d. STREET ADDRESS Not given LeDeau Gardens Nursing Home	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) LeDeau Gardens Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Olga Constance Pineau		4. DATE OF DEATH Month June Day 4 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/22/84
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 8 Days 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Ill.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Otto Erickson		14. MOTHER'S MAIDEN NAME Ida Olson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Nursing Home Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inter Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 900.0			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 7 1/2 hrs years	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down steps did not contribute to death	
20c. TIME OF INJURY Month, Day, Year 11:45 a.m. 6/4/58	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Silver Spring, Montg. Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED June 5, 1958	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation	22b. DATE THEREOF 6/5/58	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumfrey		24a. REC'D BY REGISTRAR Bethesda, Maryland	
24b. REGISTRAR'S SIGNATURE Alfred		DATE JUN 9 '58	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07048

Reg. Dist. No.

1
FOR STATE
HEALTH DEPT.

6963

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Woodmont Country Club		d. STREET ADDRESS 2737 Devenshire Place, N. W.	
3. NAME OF DECEASED (Type or print) Samuel M. Pocker		4. DATE OF DEATH Month June Day 19 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/19/1905
9. AGE (In years last birthday) 53 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner of Pockers Book Shop D.C.	
11. BIRTHPLACE (State or foreign country) N.Y.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Max Pocker		14. MOTHER'S MAIDEN NAME Bessie Gratthler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Woodmont C.C. Record	
17. INFORMANT Woodmont C.C. Record		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		DATE SIGNED 6/19/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 22, 1958	
22c. NAME OF CEMETERY OR CREMATORY Washington Hebrew Cong. Cem.		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons-3501 14th St., N.W.		24a. REC'D BY REGISTRAR DATE JUN 24 '58	
24b. REGISTRAR'S SIGNATURE Alfred			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
TREATMENT

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11-10-1918

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07049

Reg. Dist. No.

7062

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN TB 16 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. STREET ADDRESS 305 WINDSOR STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HAROLD RUSSELL PRANGLEY		4. DATE OF DEATH JUNE 25 1958		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/26/01		9. AGE (In years lost birthday) 56 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jeweler		10b. KIND OF BUSINESS OR INDUSTRY Woodward & Lothrop Dept. Store		11. BIRTHPLACE (State or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME EMANUEL PRANGLEY		14. MOTHER'S MAIDEN NAME ANNA SCHNEITMAN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 284-03-3267		17. INFORMANT Mrs. Pauline S. Prangley, 305 Windsor St.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Dehitation 584x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cholecystectomy DUE TO (c) Cholelithiasis		INTERVAL BETWEEN ONSET AND DEATH 3 hours 2 months 1 year		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Poisoning of Abscess Sub. Diaphragmatic		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from January 30 1958 , to June 25 1958 , that I last saw the deceased alive on June 25 1958 , and that death occurred at 2:23 AM , from the causes and on the date stated above.		22. I certify that I attended the deceased from January 30 1958 , to June 25 1958 , that I last saw the deceased alive on June 25 1958 , and that death occurred at 2:23 AM , from the causes and on the date stated above.	
21. I certify that I attended the deceased from January 30 1958 , to June 25 1958 , that I last saw the deceased alive on June 25 1958 , and that death occurred at 2:23 AM , from the causes and on the date stated above.		22. I certify that I attended the deceased from January 30 1958 , to June 25 1958 , that I last saw the deceased alive on June 25 1958 , and that death occurred at 2:23 AM , from the causes and on the date stated above.		23. I certify that I attended the deceased from January 30 1958 , to June 25 1958 , that I last saw the deceased alive on June 25 1958 , and that death occurred at 2:23 AM , from the causes and on the date stated above.		24. I certify that I attended the deceased from January 30 1958 , to June 25 1958 , that I last saw the deceased alive on June 25 1958 , and that death occurred at 2:23 AM , from the causes and on the date stated above.		25. I certify that I attended the deceased from January 30 1958 , to June 25 1958 , that I last saw the deceased alive on June 25 1958 , and that death occurred at 2:23 AM , from the causes and on the date stated above.		26. I certify that I attended the deceased from January 30 1958 , to June 25 1958 , that I last saw the deceased alive on June 25 1958 , and that death occurred at 2:23 AM , from the causes and on the date stated above.		27. I certify that I attended the deceased from January 30 1958 , to June 25 1958 , that I last saw the deceased alive on June 25 1958 , and that death occurred at 2:23 AM , from the causes and on the date stated above.	
22a. BURIAL, CREMATION, REMOVAL (Specify) INTERMENT		22b. DATE THEREOF 6/27/58		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) PRINCE GEO. COUNTY, MD.		23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey,		24. ADDRESS SILVER SPRING, MD.		25. REC'D BY REGISTRAR JUN 27 58	
26. REGISTRAR'S SIGNATURE W. B. Wardrop		27. REGISTRAR'S SIGNATURE W. B. Wardrop		28. REGISTRAR'S SIGNATURE W. B. Wardrop		29. REGISTRAR'S SIGNATURE W. B. Wardrop		30. REGISTRAR'S SIGNATURE W. B. Wardrop		31. REGISTRAR'S SIGNATURE W. B. Wardrop		32. REGISTRAR'S SIGNATURE W. B. Wardrop	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07050

6955

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park, Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Chevy Chase</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital 4600 Drummond Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Elise Emeline Prescott</i>		4. DATE OF DEATH Month Day Year <i>June 8 1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 21, 1925</i>
9. AGE (In years last birthday) <i>33 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Colo.</i>	
11. BIRTHPLACE (State or foreign country) <i>Colo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>	
13. FATHER'S NAME <i>Albert E. Keller</i>		14. MOTHER'S MAIDEN NAME <i>Helen Cornish</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Pt's Chart</i>	
17. INFORMANT <i>Pt's Chart</i>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Post-partum Toxemia</i> <i>686X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>13 1/2 hrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <i>Jan 2</i> , 1955, to <i>June 8</i> , 1958, that I last saw the deceased alive on <i>June 8</i> , 1958, and that death occurred at <i>230 PM</i> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>Katharine A. Chapman</i> M.D.	ADDRESS (Street, city or town, state) <i>3934 Baltimore St. Kensington, Md.</i>
PHYSICIAN'S NAME (Type) <i>Katharine Chapman, MD</i>	DATE SIGNED <i>June 8, 1958</i>

22a. BURIAL, CREMATION, REMOVAL, etc. <i>CREMATION</i>	22b. DATE THEREOF <i>6/9/1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>	22d. LOCATION (City, town, or county) (State) <i>Suitland, Maryland.</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph L. ...</i>	ADDRESS <i>1756 Pk. N.W. D.C.</i>	24a. REC'D BY REGISTRAR <i>June 10 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Alfred ...</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

Order: Bill Greenberg, Baltimore, Maryland.

Johnston, William, MD

1910

7063

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
c. LENGTH OF STAY IN 1b 2 1/2 Yrs.		d. STREET ADDRESS 8519 Pelham Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8519 Pelham Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MEYER Middle -- Last PUSCHETT		4. DATE OF DEATH Month June Day 27 , Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1889
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 7 Days 8 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired.		10b. KIND OF BUSINESS OR INDUSTRY Retired.	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Jules Puschett		14. MOTHER'S MAIDEN NAME Rachael ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 176-24-1479	
17. INFORMANT Daughter		Address Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure - arteriosclerosis 5 yrs. DUE TO (c) Prior C.V.A.		INTERVAL BETWEEN ONSET AND DEATH Immediate 1946	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 1952 to June 1958 , that I last saw the deceased alive on April 30, 1958 , and that death occurred at 2 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) approx 12-4 am, 10111 Coleridge Rd, Silver Spring, Md. DATE SIGNED 6/27/58			
ACTUAL SIGNATURE A. F. THIBADEAU		PHYSICIAN'S NAME (Type) A. F. THIBADEAU	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 6-29-58		22b. DATE THEREOF 6-29-58	
22c. NAME OF CEMETERY OR CREMATORY Beth Israel Cem.		22d. LOCATION (City, town, or county) (State) Luzerne County, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR JUN 30 '58		24b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. Pages 3 and 4 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6956

CERTIFICATE OF DEATH

Reg. Dist. No.

07052

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Md c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San. + Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 56 d. STREET ADDRESS 10120 Capital View Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William First Lewis Middle Rabbi H Sr. Last		4. DATE OF DEATH Month 6 Day 28 Year 1958					
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/19/98	9. AGE (In years last birthday) 59 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sailor		10b. KIND OF BUSINESS OR INDUSTRY MONT. COUNTY, MD.		11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME William A. Rabbitt		14. MOTHER'S MAIDEN NAME Martha J. Kemp					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Pts. Hosp. Record		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage massive DUE TO 330x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aneurysm middle cerebral artery DUE TO Prob congenital (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6-28, 1958 , to 6-28, 1958 , that I last saw the deceased alive on 6-28, 1958 , and that death occurred at 11:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Abraham W. Dankst		ADDRESS (Street, city or town, state) 927 Pershing Rd.		DATE SIGNED 6-28-58			
PHYSICIAN'S NAME (Type) ABRAHAM W. DANKST		Silver Spring, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/1/58		22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY			
				22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE Marion E. Humphrey		ADDRESS Silver Spring, Md		24a. REC'D BY REGISTRAR DATE JUL 2 '58			
				24b. REGISTRAR'S SIGNATURE Overman			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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7064

CERTIFICATE OF DEATH

Reg. Dist. No.

215.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 4 mos. 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 2907 N. Edison	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lewis Middle Hayes Last RANDALL		4. DATE OF DEATH Month June Day 18 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 August 1876
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Salesman		10b. KIND OF BUSINESS OR INDUSTRY Commercial	11. BIRTHPLACE (State or foreign country) Michigan
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Stephen RANDALL		14. MOTHER'S MAIDEN NAME Lenah JOHNSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes Spanish Am. War.		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Official Navy Records
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident (hemorrhage) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 331x (c) 24 hrs.		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Prostate with vertebral metastases		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 Feb. , 19 58 , to 18 June , 19 58 , that I last saw the deceased alive on 18 June , 19 58 , and that death occurred at 11:20AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 6-18-58			
ACTUAL SIGNATURE John A. Lynch		M.D. U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) JOHN A LYNCH, LT, MC, USNR		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-22-58	
22c. NAME OF CEMETERY OR CREMATORY Spring Grove Cemetery		22d. LOCATION (City, town, or county) (State) Medina, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Arlington Funeral Home, 3901 N. Fairfax Dr.		24a. REC'D BY REGISTRAR DATE JUN 20 '58	
24b. REGISTRAR'S SIGNATURE W. H. Beach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7065

CERTIFICATE OF DEATH

Reg. Dist. No.

07054

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 28	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 1615.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 7401 25th Avenue	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last RASMUSSEN		4. DATE OF DEATH Month June Day 3 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-2-58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Johannes L. RASMUSSEN		14. MOTHER'S MAIDEN NAME Helen Marie TUTT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Johannes L. Rasmussen (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia 761.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fetal dystoxia DUE TO (c) - - -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - - -			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 June , 19 58 , to 3 June , 19 58 , that I last saw the deceased alive on 3 June , 19 58 , and that death occurred at 10:52A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John H. Mazur		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 6-6-58	
PHYSICIAN'S NAME (Type) JOHN H. MAZUR, LT MC USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-9-58	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Bob Humphrey		24a. REC'D BY REGISTRAR DATE JUN 9 '58	
ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24b. REGISTRAR'S SIGNATURE Q. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10-17-78

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7066

CERTIFICATE OF DEATH

07055

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Lee Last RHODES		4. DATE OF DEATH Month June Day 13 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1888
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Scientific Assistant		10b. KIND OF BUSINESS OR INDUSTRY U.S. Dept. Agriculture	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David H. RHODES		14. MOTHER'S MAIDEN NAME Rachel BELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT (Son) David H. Rhodes, Brookville Road,		Address Chevy Chase, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 Bronchiogenic Carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May 29 , 19 58 , to June 13 , 19 58 , that I last saw the deceased alive on June 13 , 19 58 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Jerome A. Gold		ADDRESS (Street, city or town, state) U.S. Naval Hospital, NMMC	
PHYSICIAN'S NAME (Type) Jerome A. GOLD, LT, MC, USN		DATE SIGNED 6-14-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-18-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR W. H. 16 '58		24b. REGISTRAR'S SIGNATURE W. H. 16 '58	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07056

7067

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLESVILLE		c. LENGTH OF STAY IN 1b 5 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 41 SHAW AVENUE		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ETHEL BLAKE RICHARDS		4. DATE OF DEATH June 23 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/9/77
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) ILLINOIS
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME AARON BENSON BLAKE		14. MOTHER'S MAIDEN NAME MILLCENT CULP	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Helen R. Sigler, 41 Shaw Ave., Colesville, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) 115 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		INTERVAL BETWEEN ONSET AND DEATH 115 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 22 Nov. 1957 to June 23 1958 , that I last saw the deceased alive on June 14 1958 , and that death occurred at 4:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Silver Spring, Md. June 23 1958			
ACTUAL SIGNATURE John S. Rogers		M.D. 1919	
PHYSICIAN'S NAME (Type) JOHN S. ROGERS			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6/26/58	22c. NAME OF CEMETERY OR CREMATORY COLESVILLE CEMETERY	22d. LOCATION (City, town, or county) (State) COLESVILLE, MONTGOMERY COUNTY, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Warner & Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR JUN 24 1958		24b. REGISTRAR'S SIGNATURE W. H. Smith	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7068

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 41 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Summerfield Middle Jackson Last Richardson				4. DATE OF DEATH Month June Day 19 , Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 15, 1903	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner				10b. KIND OF BUSINESS OR INDUSTRY Mining		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Richardson				14. MOTHER'S MAIDEN NAME Rachel Greenway			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 208-09-1151		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopleural Fistula DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lung Abscess DUE TO (c) Pulmonary Emboli INTERVAL BETWEEN ONSET AND DEATH 1 mo. 1-4 mo. about 2 mo.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic Heart Disease & Mitral Valvulitis, old + inactive							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 9, 1958 , to June 19, 1958 , that I last saw the deceased alive on June 19, 1958 , and that death occurred at 10:35 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas N. Lynn Jr. M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
DATE SIGNED 6/20/58							
PHYSICIAN'S NAME (Type) Thomas N. Lynn, Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF 6/20/58		22c. NAME OF CEMETERY OR CREMATORY	
22d. LOCATION (City, town, or county) (State) Portage, Penna.							
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W.				ADDRESS Wash. D.C.		24a. REC'D BY REGISTRAR JUN 23 58	
24b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7069

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07058

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5800 Block Wilson Lane		d. STREET ADDRESS 5802 Wilson Lane	
3. NAME OF DECEASED (Type or print) Andrew Ralph Ricketts		4. DATE OF DEATH June 11, 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/15/57
9. AGE (In years last birthday) 10 yrs.		IF UNDER 1 YEAR 10 Months 26 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ralph Ricketts		14. MOTHER'S MAIDEN NAME Martha Panagopoulos	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Police Record		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage & Laceration 812x DUE TO Conditions, if any, which gave rise to immediate cause (b) Compound Fracture of Skull (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Struck by hit & run auto while in a stroler	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by hit & run auto while in a stroler		20c. TIME OF INJURY 7:05 p. m. 6.11/58	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway	
20f. (City or town) Bethesda		(County) Montg.	
(State) Md.		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED June 11, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-14-58	
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) Montgomery County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		24a. REC'D BY REGISTRAR Bethesda, Maryland	
24b. REGISTRAR'S SIGNATURE W. J. Smith		DATE JUN 16 '58	

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07059

7070

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5800 Block Wilson Lane				d. STREET ADDRESS 5802 Wilson Lane			
3. NAME OF DECEASED (Type or print) First Martha P. Middle Ricketts Last				4. DATE OF DEATH Month June Day 11 Year 1958			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/5/1938	
9. AGE (In years last birthday) 19 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) D.C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Andrew Panagopoulos				14. MOTHER'S MAIDEN NAME Rose Trois			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Police Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage 812x DUE TO (b) Fracture of skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of left femur & hip. Comp. Fracture rt. leg							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Struck by hit and run auto (pedestrian)					
20c. TIME OF INJURY Month, Day, Year 7:05 p.m. 6.11/58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway		20f. (City or town) (County) (State) Bethesda Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 6/11/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-14-58		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE JUN 16 '58	
				24b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH - BATHING
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Montgomery

Montgomery

Bohemia

Bohemia

3800 Wood Wilson Lane

3800 Wood Wilson Lane

Bohemia

Bohemia

Bohemia

Bohemia

Bohemia

Bohemia

Bohemia

Andrew Knapton St

Andrew Knapton St

Police Record

Cerebral hemorrhage

Fracture of skull

Fracture of left femur & hip. Gird. fracture of left
[Bohemia] by his and son also (Bohemia)

Bohemia

Bohemia

Bohemia

Bohemia

Bohemia

Bohemia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Item 9 File G231 7-23-58 et 7071 CERTIFICATE OF DEATH

07060

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Laytonsville	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Samuel Last Riggs		4. DATE OF DEATH Month June Day 16 Year 19 58	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1880
9. AGE (In years last birthday) 77 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Riggs		14. MOTHER'S MAIDEN NAME Louise Wood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Unk own	
17. INFORMANT Mrs. H. Samuel Riggs		Address -Rt. #1 Gaithersburg Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, Generalized DUE TO (c) Many years		INTERVAL BETWEEN ONSET AND DEATH 48 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis, Severe;		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/20 , 1955, to 6/16 , 1958, that I last saw the deceased alive on 6/16 , 1958, and that death occurred at 11:04 , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Damascus, Maryland DATE SIGNED 6/17/58 ACTUAL SIGNATURE G. F. Meadors M.D. PHYSICIAN'S NAME (Type) G. F. Meadors, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 18, 1958	
22c. NAME OF CEMETERY OR CREMATORY Goshen Cemetery		22d. LOCATION (City, town, or county) (State) Goshen, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber		24a. REC'D BY REGISTRAR DATE JUN 19 '58	
ADDRESS Laytonville, Md.		24b. REGISTRAR'S SIGNATURE Alfred	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7072

CERTIFICATE OF DEATH

Reg. Dist. No. 07061

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 4 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 508 Gilmore Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edwin Rolla		4. DATE OF DEATH June 14 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/18/67
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tour Dir. for Foreign Countries—own business		10b. KIND OF BUSINESS OR INDUSTRY Lime Springs, Iowa	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Rochester		14. MOTHER'S MAIDEN NAME Annette	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 579-24-7247A	
17. INFORMANT Mrs. Edna B. Rochester, 508 Gilmore Dr.		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia (Terminal) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Chronic myocarditis = Cardiac failure (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 days Undetermined Undetermined	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X Senility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 12, 19 51 to June 14, 19 58 , that I last saw the deceased alive on June 13, 19 58 , and that death occurred at 10:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE George L Ball		ADDRESS (Street, city or town, state) 7835 Eastern Ave Silver Spring, Md.	
PHYSICIAN'S NAME (Type) George L Ball		DATE SIGNED June 14, 19 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 6/17/58	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY	
23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR JUN 17 '58		24b. REGISTRAR'S SIGNATURE W. B. Search	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1913

DECEASED NAME JAMES H. HARRIS		SEX Male		AGE 68	
PLACE OF BIRTH BALTIMORE, MD		OCCUPATION Retired		MARITAL STATUS Married	
DATE OF DEATH Jan 15 1913		TIME OF DEATH 10:30 AM		PLACE OF DEATH Home	
CAUSE OF DEATH Heart Failure		DISEASE OR INJURY None		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. H. Harris		SIGNATURE OF WITNESS J. H. Harris		SIGNATURE OF DECEASED J. H. Harris	
SIGNATURE OF REGISTRAR J. H. Harris		SIGNATURE OF CLERK J. H. Harris		SIGNATURE OF JURY J. H. Harris	

7073

CERTIFICATE OF DEATH

Reg. Dist. No.

08193
215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Middle ROCK Last ROCK				4. DATE OF DEATH Month June Day 29 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-28-58	
9. AGE (In years last birthday) yrs. 1		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min 58		IF UNDER 24 HRS. Months 1 Days 1 Hours 1 Min 58			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Robert Ronald ROCK				14. MOTHER'S MAIDEN NAME Margaret Ann MELODY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address Father, Robert R. ROCK (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fetal Alelectasis DUE TO (c) Prematurity INTERVAL BETWEEN ONSET AND DEATH 31 hrs 16 min							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 28 June , 19 58 , to 29 June , 19 58 , that I lost saw the deceased alive on 29 June , 19 58 , and that death occurred at 12:25 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Adam T. Thorp, Jr. M.D.				ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 6-30-58			
PHYSICIAN'S NAME (Type) Adam T. Thorp, Jr. LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3 July 1958		22c. NAME OF CEMETERY OR CREMATORY Holy Face Cemetery		22d. LOCATION (City, town, or county) (State) Great Mills, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. C. Mattingley, Leonardtown, Md.				24a. REC'D BY REGISTRAR JUL 9 '58		24b. REGISTRAR'S SIGNATURE W. C. Mattingley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
EDUCATION		RELIGION		MARRIAGE		PREVIOUS ILLNESS		TREATMENT		HISTORY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME		SIGNATURE OF COUNTY CLERK		SIGNATURE OF STATE DEPARTMENT OF HEALTH	
DATE OF SIGNATURE		TIME OF SIGNATURE		PLACE OF SIGNATURE		CAUSE OF SIGNATURE		MANNER OF SIGNATURE		OCCUPATION OF SIGNATURE	

RECEIVED
JAN 10 1910

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7074 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07062

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville	
		f. STREET ADDRESS 103 Dawson Avenue	
3. NAME OF DECEASED (Type or print) Mary		4. DATE OF DEATH Month 6 Day 27 Year 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/20/92
		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 6 Days 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Homemaker	11. BIRTHPLACE (State or foreign country) Virginia
13. FATHER'S NAME TivB aker		14. MOTHER'S MAIDEN NAME ? Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Emmett Rogers - Husband
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRAPONTINE HEMORRHAGE 825x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL TRAUMA DUE TO (c) AUTOMOBILE ACCIDENT			INTERVAL BETWEEN ONSET AND DEATH 27 hrs 27 hrs 27 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger involved in auto accident	
20c. TIME OF INJURY Month, Day, Year Hour 7:30 P. M. 6/26/58		20d. PLACE OF INJURY (State, city, town, or county) Rockville, Md.	
21. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 6/28/58	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF 7-1-58	
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		24a. REG'D BY REGISTRAR JUN 30 58	
ADDRESS Bethesda, Md.		24b. REGISTRAR'S SIGNATURE W. J. ...	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
NOT A MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name		John A. [unclear]	
Sex		Male	
Age		65	
Race		Negro	
Birth Date		1/1/18	
Birth Place		Baltimore	
Residence		102 Madison Avenue	
Occupation		I day	
Cause of Death		Heart - [unclear]	
Date of Death		[unclear]	
Time of Death		[unclear]	
Place of Death		[unclear]	
Physician		[unclear]	
Hospital		[unclear]	
Manner of Death		[unclear]	
Signature		[unclear]	
Date		[unclear]	

X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7075

CERTIFICATE OF DEATH

Reg. Dist. No. 07063

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Florida b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 227 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 14832 Highway Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Thomas Middle Bernie Last Rucker		4. DATE OF DEATH		Month June Day 2 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 10, 1898		9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas E. Rucker				14. MOTHER'S MAIDEN NAME Minnie L. Bennett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 265-24-3780		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure 1950 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Cystopyelitis (c) Adrenal Carcinoma with widespread metastases PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tracheobronchitis							INTERVAL BETWEEN ONSET AND DEATH ~1 month ? (chronic) > 7 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 18, 19 57 , to June 2, 19 58 , that I last saw the deceased alive on June 2, 19 58 , and that death occurred at 7:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE S. M. Kahn		M.D. The Clinical Center		ADDRESS (Street, city or town, state)		DATE SIGNED 6/3/58	
PHYSICIAN'S NAME (Type) S. M. Kahn, M. D.		National Institutes of Health		Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 6/4/58		22c. NAME OF CEMETERY OR CREMATORY Edgewood Cemetery		22d. LOCATION (City, town, or county) (State) Jacksonville, Florida	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUN 6 '58	
				24b. REGISTRAR'S SIGNATURE Alfred Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
John Doe		Male		45		1910-01-01		1955-03-15		Baltimore, Md.		Heart Disease		Natural		[Signature]		[Signature]	
11. Occupation		12. Education		13. Marital status		14. Usual residence		15. Usual place of work		16. Name of attending physician		17. Name of hospital		18. Name of funeral home		19. Name of cemetery		20. Name of undertaker	
Teacher		High School		Married		Baltimore, Md.		Baltimore, Md.		Dr. Smith		St. Mary's		Doe & Sons		Greenwood		Doe & Sons	
21. Name of informant		22. Relationship to deceased		23. Address of informant		24. Telephone number		25. Name of registrar		26. Signature of registrar		27. Date of registration		28. Name of registrar		29. Signature of registrar		30. Date of registration	
Jane Doe		Wife		123 Main St.		555-1234		John Doe		[Signature]		1955-03-15		John Doe		[Signature]		1955-03-15	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07064

7076

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b 1 mo. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md. d. STREET ADDRESS RT. #1 Box 221 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John J. Ryan		4. DATE OF DEATH Month Day Year June 6 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1893
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farmer	
11. BIRTHPLACE (State or foreign country) Conn.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME John Thomas Ryan		14. MOTHER'S MAIDEN NAME Margaret Carroll	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Io D. Ryan (wife)		Address same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Toxemia Peritonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Stomach (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1		INTERVAL BETWEEN ONSET AND DEATH 1 wk. 1 wk. 1 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 6 , 19 58 , to June 6 , 19 58 , that I last saw the deceased alive on June 6 , 19 58 , and that death occurred at 5:25 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Olney Md DATE SIGNED 6/6/58 ACTUAL SIGNATURE Richard A. Yates M.D. Olney Md PHYSICIAN'S NAME (Type) Dr. Richard A. Yates Olney, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/10/1958	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE MARTIN W. HYSOING COMPANY INC. 1300 N. STREET, N.W.		24a. REC'D BY REGISTRAR JUN 8 '58 DATE 24b. REGISTRAR'S SIGNATURE Al. Harris	

7077

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b Suburban Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Seneca		d. STREET ADDRESS RFD - 213 Monroe st		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Isabelle Middle D. Last SAGER		4. DATE OF DEATH Month June Day 30 Year 19 58		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 28 1909		9. AGE (In years last birthday) 48 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Industry		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME Lorenzo Sager		14. MOTHER'S MAIDEN NAME Jessie Kirby		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Lorenzo Sager R+1, Rockville Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bleeding esophageal varices DUE TO (c) Portal cirrhosis		INTERVAL BETWEEN ONSET AND DEATH 4 day 4 day unknown		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 6-30, 19-58		(County)		(State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____													
ACTUAL SIGNATURE Jason Geiger		M.D. _____											
PHYSICIAN'S NAME (Type) JASON GEIGER		931 Pershing Drive, Silver Spring, Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/3/58		22c. NAME OF CEMETERY OR CREMATORY Darnestown		22d. LOCATION (City, town, or county) Darnestown, Maryland		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		ADDRESS		24a. REC'D BY REGISTRAR JUL 7 58		24b. REGISTRAR'S SIGNATURE Arthur							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7078

CERTIFICATE OF DEATH

Reg. Dist. No. 07066

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10 BELMONT COURT		d. STREET ADDRESS 1 10 BELMONT COURT	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AUBREY Middle R. Last SAMPSELLE		4. DATE OF DEATH Month JUNE Day 10 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/9/93
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Supervisor Dining Car Dept.		10b. KIND OF BUSINESS OR INDUSTRY B.&O. Railroad	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY SAMPSELLE		14. MOTHER'S MAIDEN NAME LYDIA ROSS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Anna M. Sampselle, 10 Belmont Court Silver Spring, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral emboli DUE TO Conditions, if any, which gave rise to immediate case (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 minutes 5 years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial ischemia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-6 , 19 50 , to 6-10 , 19 58 , that I last saw the deceased alive on 6-10 , 19 58 , and that death occurred at 10:15 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W.B. Wardrop MP		ADDRESS (Street, city or town, state) DATE SIGNED 837 Bonifant St. Silver Spring, Md. 9/10/58	
PHYSICIAN'S NAME (Type) W.B. WARDROP		837 Bonifant St. Silver Spring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/13/58	
22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Wanner & Humphrey, SILVER SPRING, MD.		ADDRESS	
24a. REC'D BY REGISTRAR DATE JUN 13 '58		24b. REGISTRAR'S SIGNATURE W. Leach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7075 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07067

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Va</u> b. COUNTY <u>Arlington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>Great Falls</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> <u>83x-3</u> ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac R.</u>			d. STREET ADDRESS <u>3821 Larcum La</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Edward Miles Sargent</u>			4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1958</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-19-1910</u>		9. AGE (In years to birthday) <u>47</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frank Sargent</u>			
14. MOTHER'S MAIDEN NAME <u>Margaret McDonald</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Wm Sargent - Same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>929.8</u> DUE TO <u>Asphyxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>drowning</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in Potomac R.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Unknown - Had been missing since 5-3-58</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>?</u> a. m. <u>?</u> p. m. <u>1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Potomac R</u>		20f. (City or town) (County) (State) <u>Great Falls</u> <u>Montgomery</u> <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6-3-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/5/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Columbia Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 6 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Search</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NOT 2 ARE
HEALTH OFF

Form with multiple sections for medical examination and death certification, including fields for name, date, time, and signature.

NAME OF DECEASED: _____

DATE OF DEATH: _____

TIME OF DEATH: _____

PLACE OF DEATH: _____

CAUSE OF DEATH: _____

MANNER OF DEATH: _____

SIGNATURE OF MEDICAL EXAMINER: _____

DATE OF SIGNATURE: _____

OFFICE OF THE MEDICAL EXAMINER: _____

REMARKS: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G230 6-12-58 et

7080

CERTIFICATE OF DEATH

07068

Reg. Dist. No. 07068

1. PLACE OF DEATH a. COUNTY Montgomery Co. Hospital MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville Olney				c. LENGTH OF STAY IN b. 420½ hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County Gen. Hospital				d. STREET ADDRESS Emory Grove Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THOMAS				4. DATE OF DEATH Month 6 Day 1 Year 1958			
5. SEX Male		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-25-92	
9. AGE (In years last birthday) 65 7/6 yrs.		IF UNDER 1 YEAR Months 6 Days 1 Hours 15 Min.		IF UNDER 24 HRS. Months 6 Days 1 Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) invalid				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland, Mont. Co.	
13. FATHER'S NAME Henry Sellman				14. MOTHER'S MAIDEN NAME Rosa Ella Fitzbugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown				16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Apoplexy, Thrombotic DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May , 19 58 , to June , 19 58 , that I last saw the deceased alive on June 1 , 19 58 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE A. D. Bonifant				M.D. Sandy Spring Md 6/3/58			
PHYSICIAN'S NAME (Type) A. D. Bonifant				sandy Spring Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-3-58		22c. NAME OF CEMETERY OR CREMATORY Church Cemetery		22d. LOCATION (City, town, or county) (State) EMORY GROVE Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R. L. Snowden				ADDRESS Rockville, Md		24a. REC'D BY REGISTRAR JUN 5 '58	
						24b. REGISTRAR'S SIGNATURE W. H. Brown	

CERTIFICATE OF DEATH

7020

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. DATE OF BIRTH [REDACTED]</p>	
<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. OCCUPATION [REDACTED]</p>	
<p>7. MARITAL STATUS [REDACTED]</p>		<p>8. DATE OF MARRIAGE [REDACTED]</p>	
<p>9. PLACE OF DEATH [REDACTED]</p>		<p>10. DATE OF DEATH [REDACTED]</p>	
<p>11. TIME OF DEATH [REDACTED]</p>		<p>12. CAUSE OF DEATH [REDACTED]</p>	
<p>13. MEDICAL HISTORY [REDACTED]</p>		<p>14. HISTORY OF PRESENT ILLNESS [REDACTED]</p>	
<p>15. PHYSICIAN'S SIGNATURE [REDACTED]</p>		<p>16. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>17. SIGNATURE OF WITNESS [REDACTED]</p>		<p>18. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>19. SIGNATURE OF WITNESS [REDACTED]</p>		<p>20. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>21. SIGNATURE OF WITNESS [REDACTED]</p>		<p>22. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>23. SIGNATURE OF WITNESS [REDACTED]</p>		<p>24. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>25. SIGNATURE OF WITNESS [REDACTED]</p>		<p>26. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>27. SIGNATURE OF WITNESS [REDACTED]</p>		<p>28. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>29. SIGNATURE OF WITNESS [REDACTED]</p>		<p>30. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>31. SIGNATURE OF WITNESS [REDACTED]</p>		<p>32. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>33. SIGNATURE OF WITNESS [REDACTED]</p>		<p>34. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>35. SIGNATURE OF WITNESS [REDACTED]</p>		<p>36. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>37. SIGNATURE OF WITNESS [REDACTED]</p>		<p>38. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>39. SIGNATURE OF WITNESS [REDACTED]</p>		<p>40. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>41. SIGNATURE OF WITNESS [REDACTED]</p>		<p>42. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>43. SIGNATURE OF WITNESS [REDACTED]</p>		<p>44. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>45. SIGNATURE OF WITNESS [REDACTED]</p>		<p>46. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>47. SIGNATURE OF WITNESS [REDACTED]</p>		<p>48. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>49. SIGNATURE OF WITNESS [REDACTED]</p>		<p>50. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>51. SIGNATURE OF WITNESS [REDACTED]</p>		<p>52. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>53. SIGNATURE OF WITNESS [REDACTED]</p>		<p>54. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>55. SIGNATURE OF WITNESS [REDACTED]</p>		<p>56. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>57. SIGNATURE OF WITNESS [REDACTED]</p>		<p>58. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>59. SIGNATURE OF WITNESS [REDACTED]</p>		<p>60. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>61. SIGNATURE OF WITNESS [REDACTED]</p>		<p>62. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>63. SIGNATURE OF WITNESS [REDACTED]</p>		<p>64. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>65. SIGNATURE OF WITNESS [REDACTED]</p>		<p>66. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>67. SIGNATURE OF WITNESS [REDACTED]</p>		<p>68. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>69. SIGNATURE OF WITNESS [REDACTED]</p>		<p>70. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>71. SIGNATURE OF WITNESS [REDACTED]</p>		<p>72. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>73. SIGNATURE OF WITNESS [REDACTED]</p>		<p>74. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>75. SIGNATURE OF WITNESS [REDACTED]</p>		<p>76. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>77. SIGNATURE OF WITNESS [REDACTED]</p>		<p>78. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>79. SIGNATURE OF WITNESS [REDACTED]</p>		<p>80. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>81. SIGNATURE OF WITNESS [REDACTED]</p>		<p>82. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>83. SIGNATURE OF WITNESS [REDACTED]</p>		<p>84. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>85. SIGNATURE OF WITNESS [REDACTED]</p>		<p>86. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>87. SIGNATURE OF WITNESS [REDACTED]</p>		<p>88. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>89. SIGNATURE OF WITNESS [REDACTED]</p>		<p>90. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>91. SIGNATURE OF WITNESS [REDACTED]</p>		<p>92. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>93. SIGNATURE OF WITNESS [REDACTED]</p>		<p>94. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>95. SIGNATURE OF WITNESS [REDACTED]</p>		<p>96. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>97. SIGNATURE OF WITNESS [REDACTED]</p>		<p>98. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>99. SIGNATURE OF WITNESS [REDACTED]</p>		<p>100. SIGNATURE OF DECEASED [REDACTED]</p>	

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		d. STREET ADDRESS 4937 Cordell Avenue	
3. NAME OF DECEASED (Type or print) Last Shackelford, Middle E. First First Sophie		4. DATE OF DEATH Month June Day 27 Year 19 58	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/7/69
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Ruben Harlow		14. MOTHER'S MAIDEN NAME Elizabeth Gillispie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. No	
17. INFORMANT Myrtle E Donaldson- Item#2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia 586X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Subdiaphragmatic & Retroperitoneal Abscess DUE TO (c) Biliary Obstruction with Secondary Cholangitis		INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 27, 1958 to June 27, 1958 , that I last saw the deceased alive on June 27, 1958 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George A. Gray Jr.		ADDRESS (Street, city or town, state) 104 Cherry Chase DR. Cherry Chase 15, Md.	
PHYSICIAN'S NAME (Type) Geo. A. Gray Jr.		DATE SIGNED 6/27/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/30/58	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	22d. LOCATION (City, town, or county) (State) Prince George Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE R.D. Humphrey		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE JUN 30 '58		24b. REGISTRAR'S SIGNATURE Over	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07071

6964

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1011 Rockcrest Dr</u>				d. STREET ADDRESS <u>1011 Rockcrest Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Arthur Thomas Sheakin</u> First Middle Last				4. DATE OF DEATH <u>June 1 1958</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-27-03</u>	
				9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chaffer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>DC</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Thomas Sheakin</u>				14. MOTHER'S MAIDEN NAME <u>Rose Samaha</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>579-22-1163</u>			
				17. INFORMANT <u>Thelma Sheakin (wife) Hem #2</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>6/4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	
22d. LOCATION (City, town, or county) <u>Washington, D. C.</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 4 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. POST-MORTEM EXAMINATION	
16. SIGNATURE OF EXAMINER		17. SIGNATURE OF WITNESS		18. SIGNATURE OF CORONER		19. SIGNATURE OF JURY		20. SIGNATURE OF JUDGE	
21. SIGNATURE OF CLERK		22. SIGNATURE OF NURSE		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF DENTIST		25. SIGNATURE OF OTHER	

7082

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING 56</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>(Home)</u>				d. STREET ADDRESS <u>11527 GRANDVIEW AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>DENNIS ANTHONY SHEEHAN, SR.</u>				4. DATE OF DEATH Month Day Year <u>JUNE 28 1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 30, 1906</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSURANCE AGENT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>INSURANCE</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>JOHN JOSEPH SHEEHAN</u>				14. MOTHER'S MAIDEN NAME <u>AGNES SULLIVAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>578-05-0398</u>		17. INFORMANT <u>CATHERINE M. SHEEHAN (WIFE)</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Myeloma</u> <u>203X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>8 MONTHS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>June 28</u> , 19 <u>58</u> , to <u>June 28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 28</u> , 19 <u>58</u> , and that death occurred at <u>3:30</u> P.M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>11502 Grandview Ave, Silver Spring, Md.</u>				DATE SIGNED <u>June 28</u>			
ACTUAL SIGNATURE <u>Belden R. Reap M.D.</u>							
PHYSICIAN'S NAME (Type) <u>BELDEN R. REAP M.D. Silver Spring, Md. 1958</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-2-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Olave Cemetery</u>		22d. LOCATION (City, town, or county) <u>Washington DC.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u> ADDRESS <u>3821-14th N.W. Wash. DC.</u>				24a. REC'D BY REGISTRAR <u>June 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MD.		DATE OF DEATH 1911	
NAME OF DECEASED JOHN DOE		SEX Male	
AGE 45		RACE White	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Clerk	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
TIME OF DEATH 10:00 AM		PLACE OF DEATH Home	
SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF REGISTRAR A. B. Jones	
CERTIFICATE OF DEATH This is to certify that the above named person died on the 1st day of January, 1911, at the age of 45 years, of Heart Disease, at his home, Baltimore, Md.		I hereby certify that the above named person died on the 1st day of January, 1911, at the age of 45 years, of Heart Disease, at his home, Baltimore, Md.	



This certificate is to be filed in the office of the Registrar of the Department of Health, Baltimore, Md., and a copy thereof to be sent to the office of the Registrar of the Department of Health, Annapolis, Md.

CERTIFICATE OF DEATH

07073

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>3 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. STREET ADDRESS <u>5903 Woodacres Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Davis</u> Last <u>Shelley</u>				4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 29, 1917</u>	9. AGE (In years last birthday) <u>40 1/4</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Public Relations</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>New York City, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Shelley</u>				14. MOTHER'S MAIDEN NAME <u>Kathleen McSherry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT (Wife) <u>Mrs. Veronica Shelley</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebellar pontine hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension grade III</u> DUE TO <u>2 yrs</u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>56</u> , to <u>6 June</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6 June</u> , 19 <u>58</u> , and that death occurred at <u>5:55 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5029 Bethesda Ave Bethesda Md</u> DATE SIGNED <u>6 June 58</u>							
ACTUAL SIGNATURE <u>Herbert Martyn Jr</u> M.D. <u>5029 Bethesda Ave</u>				PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR</u> <u>Bethesda Md</u> <u>6 June 58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/10/9/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR <u>DATE JUN 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alb Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7084
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, 15</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>5555 32nd ST. N.W.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Norman Bishop Sheppard</u>				4. DATE OF DEATH Month Day Year <u>June 21 1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 17, 1895</u>	9. AGE (In years lost birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Legal Consultant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Veteran's Adm.</u>		11. BIRTHPLACE (State or foreign country) <u>Conn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>John Sheppard</u>				14. MOTHER'S MAIDEN NAME <u>Mary Davidson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>1918 57912-5353</u>		17. INFORMANT <u>Mrs. Norman Sheppard Davidson</u>		Address <u>5555 32nd ST. N.W. Washington, DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>1538</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of colon</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1956</u> 1956, to <u>June 21, 1958</u> , that I last saw the deceased alive on <u>June 20</u> , 19 <u>58</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James H. Scully</u>				ADDRESS (Street, city or town, state) <u>1835 EYE ST. N.W. Washington 6 D.C.</u>			
PHYSICIAN'S NAME (Type) <u>JAMES H. SCULLY</u>				DATE SIGNED <u>JUN 23 '58</u>			
22a. BURIAL CREMATION <u>burial</u>		22b. DATE THEREOF <u>6/24/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. H. Hines</u>				ADDRESS <u>CO-2901 14th St. N.W., Wash, D.C.</u>			
				24a. REC'D BY REGISTRAR <u>Quinlan</u>			
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7085

07075

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>9 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3 ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Nursing Home</u>			d. STREET ADDRESS <u>4409 Ord. St. N.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Anna Wade Sherrieff</u>			4. DATE OF DEATH <u>June 28 1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-12-1864</u>	9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Peter Wood</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Skinner</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Nursing Home Record</u>		17. INFORMANT <u>Nursing Home Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1 Acute Congestive heart failure</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6-28-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 1st 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home H + M Annapolis</u>		24a. REC'D BY REGISTRAR <u>Ward DC</u>	24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	DATE <u>JUL 1 '58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7086 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07076

Reg. Disf. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN 1b 1 1/2 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BLADENSBURG 1633.2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3221 BLUFORD ROAD				d. STREET ADDRESS 4107 - 51st STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANKLIN WATERS SHREVE				4. DATE OF DEATH JUNE 21 19 58			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 20, 1904		9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY HOME FREEZER FOOD CO. DICKERSON, MD.		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME DANIEL T. SHREVE				14. MOTHER'S MAIDEN NAME EFFIE HAMMOND			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 577-01-9558		17. INFORMANT Address Mrs. Genevieve C. Shreve, 4107 51st St. Baldensburg, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SUDDEN							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				DATE SIGNED JUNE 22, 1958			
EXAMINER'S NAME (Type) FRANK J. BROSCART				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/24/58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince Geo. County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Humphrey</i>				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE JUN 24 '58	
				24b. REGISTRAR'S SIGNATURE <i>W. E. Humphrey</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7087

Item 8 Film G230 6-30-58 et

CERTIFICATE OF DEATH

07077

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkwood-Md Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				d. STREET ADDRESS 4414 Brookfield Dr			
3. NAME OF DECEASED (Type or print) First Middle Last ARTHUR W SMITH				4. DATE OF DEATH Month Day Year June 19 1958			
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/25/77	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 10 24		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steward--Retired			10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) CHATTIS. ENGLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM SMITH			14. MOTHER'S MAIDEN NAME Ann NORMAN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 131-09-5770		17. INFORMANT Norman L. Smith-10503 Wheatley St. land		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination DUE TO 581.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Bleeding Esophageal varices DUE TO Unknown (c) Cirrhosis of the liver years						INTERVAL BETWEEN ONSET AND DEATH hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7 , 1955, to June 19, 1958 , that I last saw the deceased alive on June 19, 1958 , and that death occurred at 12:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10609 Concord St. DATE SIGNED June 19 58							
ACTUAL SIGNATURE Robert T. Thibadeau				PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D. Kensington, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6/23/58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland				24a. REC'D BY REGISTRAR JUN 23 '58		24b. REGISTRAR'S SIGNATURE Allen Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07069

CERTIFICATE OF DEATH

Reg. Dist. No.

7088

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 1 1/2 hrs.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monrovia				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Snapp				4. DATE OF DEATH Month June Day 19 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 19, 1958	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours 1 Min. 30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME Patricia May Snapp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address mother	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Prematurity - 5 months pregnancy DUE TO (b) 14 1/6 lbs or 14 ounces DUE TO (c) unknown Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
INTERVAL BETWEEN ONSET AND DEATH Fixed about 1 1/2 hrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 19, 1958 , to June 19, 1958 , that I last saw the deceased alive on June 19, 1958 , and that death occurred at 9 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. A. Linthicum M.D.				ADDRESS (Street, city or town, state) 26 N. Summit Ave., Baltimore, Md.			
DATE SIGNED 6/20/58							
PHYSICIAN'S NAME (Type) W. A. Linthicum, M. D.,							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-20-1958		22c. NAME OF CEMETERY OR CREMATORY Family Plot		22d. LOCATION (City, town, or county) (State) Carroll Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz ADDRESS Winfield, Md.				24a. REC'D BY REGISTRAR DATE JUN 23 '58		24b. REGISTRAR'S SIGNATURE W. A. Linthicum	

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 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 7089 Item 7 Film 231 7-10-58 et
 CERTIFICATE OF DEATH

07078

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	c. LENGTH OF STAY IN 1b 9 mos.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Havarest Home-571 Univ. Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle S. Last Soper		4. DATE OF DEATH Month June Day 28 Year 19 58	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1878
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Franklin Duvall		14. MOTHER'S MAIDEN NAME Harriet Elizabeth Purdom	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	
17. INFORMANT William F. Soper, Chevy Chase, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes mellitus; diabetic acidosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 hours 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis severe		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19, 1952 to June 28, 1958 , that I last saw the deceased alive on June 28, 1958 , and that death occurred at 11:57 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas G. H. Hindman M.D. 3935 Baltimore St. Kensington, Md. 6/29/58		ADDRESS (Street, city or town, state) DATE SIGNED Kensington Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-1-58	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Raymond Barber		ADDRESS Laytonsville, Md.	
24a. REC'D BY REGISTRAR JUL 7 '58		24b. REGISTRAR'S SIGNATURE W. H. Couch	

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE, 18

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1970-1971

7090

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Texas b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 47 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Howard Last Spears				4. DATE OF DEATH Month June Day 1 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 18, 1923	
9. AGE (In years lost birthday) 34 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic				10b. KIND OF BUSINESS OR INDUSTRY Automotive		11. BIRTHPLACE (State or foreign country) Texas	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Allan Spears				14. MOTHER'S MAIDEN NAME May Grizzell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO. 454-28-8030			
17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE LYMPHOCYTIC LEUKEMIA 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 1/2 mos.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) URIC ACID NEPHROPATHY. CNS. LEUKEMIA.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 15, 19 58 , to June 1, 19 58 , that I last saw the deceased alive on June 1, 19 58 , and that death occurred at 7:55 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard K Shaw M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
DATE SIGNED 6-2-58							
PHYSICIAN'S NAME (Type) Richard K. Shaw, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit				22b. DATE THEREOF 6/3/58		22c. NAME OF CEMETERY OR CREMATORY	
22d. LOCATION (City, town, or county) (State) Lubbock, Texas							
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland				24a. REC'D BY REGISTRAR 30N 4 58 DATE 6-2-58			
24b. REGISTRAR'S SIGNATURE W. K. Shaw							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7091

CERTIFICATE OF DEATH

Reg. Dist. No.

07080

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington D.C.</u> b. COUNTY <u>47X-3</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>2122 Mass. Ave NW</u>	
3. NAME OF DECEASED (Type or print) <u>Dr. Edward J. Stieglitz</u>		4. DATE OF DEATH <u>June 11 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 6, 1899</u> 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MEDICAL DOCTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF-EMPLOYED</u>	
11. BIRTHPLACE (State or foreign country) <u>Chicago Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JULIUS STIEGLITZ</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-243146</u>	
17. INFORMANT <u>Office Records</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>POSTERIOR MYOCARDIAL INFARCTION</u> DUE TO (c) <u>CORONARY ARTERIO SCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u> <u>3 1/2 HOURS</u> <u>2 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>JANUARY, 1958</u> , to <u>11 JUNE</u> , 1958, that I last saw the deceased alive on <u>11 JUNE</u> , 1958, and that death occurred at <u>11:40 PM</u> , from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>Seruch T. Kimble</u> M.D.		DATE SIGNED <u>11 JUNE 58</u>
PHYSICIAN'S NAME (Type) <u>Seruch T. Kimble</u>		ADDRESS (Street, city or town, state) <u>729 PERSHING DRIVE SILVER SPRING, MARYLAND</u>
22a. BURIAL (CREMATION) REMOVAL (Specify) <u>CREMATION</u>	22b. DATE THEREOF <u>6-13-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>
22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph G. Lewis</u> ADDRESS <u>Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 16 '58</u>
		24b. REGISTRAR'S SIGNATURE <u>W. Lewis</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7092

CERTIFICATE OF DEATH

Reg. Dist. No. 215

07081

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47 x 3 ✓	
3. NAME OF DECEASED (Type or print) First Helen Middle Newton Last STITT		4. DATE OF DEATH Month June Day 14 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1876
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James M. BENNETT		14. MOTHER'S MAIDEN NAME Susan S. NEWTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Dau) Helen K. NEWTON, same as #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 36 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 12 , 19 58 , to June 14 , 19 58 , that I last saw the deceased alive on June 13 , 19 58 , and that death occurred at 12:30 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE R. G. Muth		ADDRESS (Street, city or town, state) DATE SIGNED 6-14-58	
PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN		Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-16-58	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's & Sons		24a. REC'D BY REGISTRAR JUN 16 '58	
ADDRESS Washington, D.C.		24b. REGISTRAR'S SIGNATURE Deborah	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, pay the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7093
CERTIFICATE OF DEATH

07082

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mass b. COUNTY H.W.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Kensington Garden Sanitorium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary F Stitt		4. DATE OF DEATH June 14 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27-1880
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY Maysville Ky	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME unobtainable		14. MOTHER'S MAIDEN NAME unobtainable	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mrs Mergard Putnam		Address 14 24-Mass Ave. N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebrovascular accident		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 Sept. 1957 to 14 June 1958 that I last saw the deceased alive on 14 June 1958 , and that death occurred at 6:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert Martin Jr M.D.		ADDRESS (Street, city or town, state) 5029 Bethesda Ave	
PHYSICIAN'S NAME (Type) HERBERT MARTIN JR		DATE SIGNED Bethesda md 14 June 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/15/58	
22c. NAME OF CEMETERY OR CREMATORY Maysville		22d. LOCATION (City, town, or county) (State) Maysville, Ky.	
23. FUNERAL DIRECTOR'S SIGNATURE S.H. Hines Co.		24a. REC'D BY REGISTRAR JUN 17 '58	
ADDRESS 2901-14 St. Washington DC.		24b. REGISTRAR'S SIGNATURE W. H. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE

DECEASED

AGE

RESIDENCE

DATE OF BIRTH

SEX

DATE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

CAUSE OF DEATH

CAUSE OF DEATH

CAUSE OF DEATH

CAUSE OF DEATH

CAUSE OF DEATH

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CAUSE OF DEATH

CAUSE OF DEATH

CAUSE OF DEATH

6965

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>			
c. LENGTH OF STAY IN 1b <u>1 yr. 3 mo.</u>				d. STREET ADDRESS <u>321 East Third Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>805 Crothers Lane</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <u>Katie</u> Middle <u>Fraley</u> Last <u>Stone</u>		4. DATE OF DEATH		Month <u>June</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 18, 1879</u>		9. AGE (In years last birthday) <u>79 yrs.</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Feagville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George C. Stone</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Fraley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Betty R. Turner, 805 Crothers Lane</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerotic heart disease with aortic stenosis</u> DUE TO <u>stenosis</u> (c)							INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio sclerotic heart disease with aortic stenosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>November</u> 19 <u>57</u> , to <u>June 26</u> 19 <u>58</u> , that I last saw the deceased alive on <u>June 17</u> 19 <u>58</u> , and that death occurred at <u>10:30AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Herman C. Maganzini</u>		M.D. <u>809 Viers Mill Road</u> <u>June 26, 1958</u>					
PHYSICIAN'S NAME (Type) <u>Herman C. Maganzini</u>		<u>Rockville, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/28/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Feagville Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton, Barnesville</u>				24a. REC'D BY REGISTRAR <u>W. B. Hilton</u>		24b. REGISTRAR'S SIGNATURE <u>W. B. Hilton</u>	
				DATE <u>JUL 1 1958</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7094
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westgate		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westgate	
d. NAME OF HOSPITAL (If not in hospital, give street address) 4914 Flint Drive, Westgate		d. STREET ADDRESS 4914 Flint Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Annie Middle L Last Sullivan		4. DATE OF DEATH Month June Day 12 , Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28, 1865
9. AGE (In years last birthday) 92		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Haley		14. MOTHER'S MAIDEN NAME Martha Virginia Drew	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. --	
17. INFORMANT Ruth S. Horner Address Md. 4914 Flint Dr. Westgate,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 792x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 , 19____, to June 12, 1958 , that I last saw the deceased alive on June 11, 1958 , and that death occurred at 7:24 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4830 V St. N.W. DATE SIGNED			
ACTUAL SIGNATURE Edward W. Nicklas M.D.			
PHYSICIAN'S NAME (Type) EDWARD W. NICKLAS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/16/58	22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St., N.W.		24a. REC'D BY REGISTRAR JUN 13 '58	24b. REGISTRAR'S SIGNATURE W. H. Seach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

07085

Reg. Dist. No. 215

7095

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charleston 85 X - 3	
3. NAME OF DECEASED (Type or print) First Kathryn Middle Isabel Last SULLIVAN		4. DATE OF DEATH Month June Day 9 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-4-15
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Stephen MARONEY		14. MOTHER'S MAIDEN NAME Edith NEASE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver 5810 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 Years
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **6-1-** 19 **58**, to **6-9-** 19 **58**, that I last saw the deceased alive on **6-9-58**, 19 **58**, and that death occurred at **3:45 P.M.** from the causes and on the date stated above.

ACTUAL SIGNATURE **Gerald I. Shugoll** M.D. ADDRESS (Street, city or town, state) **U.S. Naval Hospital, Bethesda, Md.** DATE SIGNED **6-9-58**

PHYSICIAN'S NAME (Type) **Gerald I. SHUGOLL, LT MC USN** **U.S. NAVAL HOSPITAL, BETHESDA, MD.**

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-10-58	22c. NAME OF CEMETERY OR CREMATORY Montgomery Memorial Park	22d. LOCATION (City, town, or county) (State) London, West Virginia
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23. FUNERAL DIRECTOR'S SIGNATURE Robert C. Kunkley ADDRESS Bethesda, Md.	24a. REC'D BY REGISTRAR DATE JUN 11 '58	24b. REGISTRAR'S SIGNATURE W. H. Beach
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of deceased		Sex		Age		Date of death		Place of death	
John Doe		Male		35		10-11-18		New York City	
Cause of death		Disease		Organ		Time of death		Signature of physician	
Heart failure		Myocarditis		Heart		10:30 AM		J. Smith, M.D.	
Occupation		Education		Religion		Marital status		Signature of informant	
Teacher		High School		Catholic		Single		M. Jones	
Place of birth		Date of birth		Place of death		Time of death		Signature of registrar	
New York City		10-11-18		New York City		10:30 AM		A. Brown	
Signature of registrar		Signature of physician		Signature of informant		Signature of witness		Signature of witness	
A. Brown		J. Smith, M.D.		M. Jones		C. White		D. Green	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07086

7096

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montg MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. LENGTH OF STAY IN 1b 23 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Gaithersburg Rural			
f. STREET ADDRESS RFD#2				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Vincent Middle Hurry Last Tabler				4. DATE OF DEATH Month June Day 26 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar 1st 1886	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 5 Days 25 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Merchant		11. BIRTHPLACE (State or foreign country) Hyattstown. Md.	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME George T Tabler				14. MOTHER'S MAIDEN NAME Ida Cooke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) (Yes, no. or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Mary E. Tabler. Gaithersburg. RFD. 2. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure. 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Vascular Accident DUE TO (c) Hypertension, Generalized Interocle- 26515				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 9. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 1955 , 19 55 , to 6/26 , 19 58 , that I last saw the deceased alive on 6/25 , 19 58 , and that death occurred at 11:20 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 108 N. Frederick Ave. DATE SIGNED ACTUAL SIGNATURE Luciano I. Lael M.D. PHYSICIAN'S NAME (Type) Luciano I. Lael M.D. Gaithersburg Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-28-58		22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) (State) Rockville. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner, Gaithersburg Md.				24a. REC'D BY REGISTRAR DATE JUN 30 '58		24b. REGISTRAR'S SIGNATURE Al. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

TO HOSPITAL: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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7097

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>5456-30th Pl. N.W.</i>	
3. NAME OF DECEASED (Type or print) First <i>Marita</i> Middle <i>a</i> Last <i>Tamamian</i>		4. DATE OF DEATH Month <i>June</i> Day <i>7</i> Year <i>1958</i>	
5. SEX <i>f</i>	6. COLOR OR RACE <i>white</i>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 10, 1908</i>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <i>50</i> yrs. IF UNDER 1 YEAR: Months <i>3</i> Days <i>28</i> Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Gamias, Turkey</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Stephan Cambouris</i>		14. MOTHER'S MAIDEN NAME <i>Marnos M. Kitarin</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <i>Paul Tamamian - 5456 30th Pl. N.W.</i>		Address _____	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

*2 months**4 months*

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. _____ p. m. _____ 19 _____20d. INJURY OCCURRED
While of work ☐ Not while of work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from *23 May, 1958*, to *7 June, 1958*, that I last saw the deceased alive on *7 June, 1958*, and that death occurred at *10:30 A.M.* from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE

*Herbert Martyn Jr*M.D. *H**5029 BETHESDA AVE 7/6/58*

PHYSICIAN'S NAME (Type)

*HERBERT MARTYN JR**BETHESDA MD*

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>6/10/1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>WATERTOWN, MASSACHUSETTS</i>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>MARTIN W. HYSOING CO. INC. 1300 - N. STREET, N.W.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 10 '58</i>	24b. REGISTRAR'S SIGNATURE <i>W. H. Beach</i>

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

For Use by

1. NAME OF DECEASED MAYNARD		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 1910		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Clerk		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION Roman Catholic		10. RACE White	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. PLACE OF DEATH Home		14. DATE OF DEATH 1955		15. TIME OF DEATH 10:00 AM	
16. SIGNATURE OF PHYSICIAN J. H. Smith		17. SIGNATURE OF REGISTRAR J. H. Smith		18. SIGNATURE OF WITNESS J. H. Smith		19. SIGNATURE OF DECEASED J. H. Smith		20. SIGNATURE OF NEXT OF KIN J. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07088

7098

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRESTVIEW</u>		c. LENGTH OF STAY IN 1b <u>ONE MONTH</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRESTVIEW</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4811 BAYARD BLVD.</u>				d. STREET ADDRESS <u>4811 BAYARD BLVD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>ALDIE</u> Last <u>TAYLOR</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>1</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 6, 1880</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK - RECORDER OF DEEDS - D.C. GOV.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>ALFRED EDWARD TAYLOR</u>			
14. MOTHER'S MAIDEN NAME <u>MARTHA ALICE LOVELESS</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW I</u>			
16. SOCIAL SECURITY NO. <u>577-16-2549</u>				17. INFORMANT <u>MARY ANGELA HAWKSHAW</u> Address <u>4811 BAYARD BLVD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SCARCINOMATOSIS</u> DUE TO (c) <u>SCARCINOMA OF BREAST</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 YA.</u> <u>12 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INACTIVE PULMONARY TUBERCULOSIS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>002X</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 31</u> , 19 <u>58</u> , to <u>JUNE 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JUNE 1</u> , 19 <u>58</u> , and that death occurred at <u>8:18 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward J. Witowski Jr. M.D.</u>				ADDRESS (Street, city or town, state) <u>SUITE 400, 8218 WISCONSIN AVE. JUNE 1, 1958</u>			
PHYSICIAN'S NAME (Type) <u>EDWARD J. WITOWSKI, JR. MD.</u>				DATE SIGNED <u>BETHESDA 14, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don. DeVol</u>				ADDRESS <u>2224 - W. 2. 74</u>		24a. REC'D BY REGISTRAR <u>JUN 4 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>DeVos</u>							

7099

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>560 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>1920 Grace Church Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Louisa</u> Last <u>Terhune</u>				4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 26, 1885</u>	9. AGE (In years lost birthday) <u>73</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Richard Seymour</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Fillagore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Myrtle Howard</u> Address <u>Same as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock and Toxemia</u> <u>570.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Intestinal infarction, ileum</u> DUE TO (c) <u>Mesenteric venous thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u> <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral infarctions due to arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1954</u> to <u>June 10, 1958</u> , that I last saw the deceased alive on <u>June 10, 1958</u> , and that death occurred at <u>9 P</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>George Sharpe</u> M.D. <u>10511 Summit Ave</u>				<u>6/11/58</u>			
PHYSICIAN'S NAME (Type) <u>George Sharpe M.D.</u>				<u>Kensington, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>6/14/58</u>		<u>MT. MORIAN CEMETERY</u>		<u>PHILADELPHIA, PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	
<u>Warner E. Rumphrey</u> <u>SILVER SPRING, MD.</u>				<u>JUN 13 '58</u>		<u>Al. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7100

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>9810 Georgia Ave. S.D.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mong.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Liberty Spring</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maple Lane San.</u>				d. STREET ADDRESS <u>12030 Centhill</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Kathryn</u> Last <u>Tull</u>				4. DATE OF DEATH Month <u>6</u> Day <u>24</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 8, 1894</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>KIDDER</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Lucille Nestler</u> Address <u>12030 Centhill Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260X</u> (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>Congestive Heart failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>1-2 week</u> <u>years</u> <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus and Decubitus ulcers</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part-II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>November 1, 1956</u> , to <u>1958</u> , that I last saw the deceased alive on <u>1958</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9300 Ewing Drive, Bethesda, Md.</u> DATE SIGNED <u>SEYMOUR GREENBAUM, M.D.</u>							
ACTUAL SIGNATURE <u>SEYMOUR GREENBAUM, M.D.</u> <u>9300 EWING DR. BETHESDA, MD.</u>							
PHYSICIAN'S NAME (Type) <u>SEYMOUR GREENBAUM, M.D.</u> <u>9300 EWING DR. BETHESDA, MD.</u>							
22a. BURIAL, CREMATION, <u>BURIAL</u> (Specify)		22b. DATE THEREOF <u>6-26-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL</u>		22d. LOCATION (City, town, or county) (State) <u>FT MYER, VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS, CO.</u> ADDRESS <u>1400 CHAPIN ST. NW</u>				24a. REC'D BY REGISTRAR <u>W.W. Chambers</u> DATE <u>JUN 25 '58</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 1 1/2 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Bernice Melissa TURNER				4. DATE OF DEATH Month Day Year June 17 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH July 10, 1915	
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 11 7		IF UNDER 24 HRS. 7			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper				10b. KIND OF BUSINESS OR INDUSTRY Country Club			
11. BIRTHPLACE (State or foreign country) South Carolina				12. CITIZEN OF WHAT COUNTRY? America			
13. FATHER'S NAME Raleb A. Setzer				14. MOTHER'S MAIDEN NAME Myrtle Bradley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Lila L. Swartz				Address 1023 N. Barton Arlington, Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 2 YRS INTERVAL BETWEEN ONSET AND DEATH 36 HRS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 16, 1958 to June 17, 1958 , that I last saw the deceased alive on June 16, 1958 , and that death occurred at 3:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo I Donovau M.D.				ADDRESS (Street, city or town, state) 6016 Hensley Rd Bethesda 14 MD			
DATE SIGNED 6/17/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/19/58		22c. NAME OF CEMETERY OR CREMATORY Burtonsville Cemetery		22d. LOCATION (City, town, or county) (State) Burtonsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR JUN 18 '58	
24b. REGISTRAR'S SIGNATURE W. H. Beach							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2104

1. Name of deceased: Charles A. Johnson

2. Sex: Male

3. Age: 45

4. Date of birth: July 15, 1900

5. Place of birth: Massachusetts

6. Date of death: August 10, 1945

7. Place of death: Home

8. Cause of death: Myocardial Infarction

9. Duration of illness: 2 days

10. Name of physician: Dr. J. H. Smith

11. Name of funeral home: Johnson & Sons

12. Name of undertaker: Johnson & Sons

13. Name of cemetery: Forest Hills

14. Name of burial place: Section 1, Lot 10

15. Name of informant: John A. Johnson

16. Address of informant: 123 Main St., Boston, Mass.

17. Signature of informant: [Signature]

18. Signature of physician: [Signature]

19. Signature of funeral home: [Signature]

20. Signature of undertaker: [Signature]

21. Signature of cemetery: [Signature]

22. Signature of burial place: [Signature]

23. Signature of informant: [Signature]

24. Signature of physician: [Signature]

25. Signature of funeral home: [Signature]

26. Signature of undertaker: [Signature]

27. Signature of cemetery: [Signature]

28. Signature of burial place: [Signature]

29. Signature of informant: [Signature]

30. Signature of physician: [Signature]

31. Signature of funeral home: [Signature]

32. Signature of undertaker: [Signature]

33. Signature of cemetery: [Signature]

34. Signature of burial place: [Signature]

35. Signature of informant: [Signature]

36. Signature of physician: [Signature]

37. Signature of funeral home: [Signature]

38. Signature of undertaker: [Signature]

39. Signature of cemetery: [Signature]

40. Signature of burial place: [Signature]

41. Signature of informant: [Signature]

42. Signature of physician: [Signature]

43. Signature of funeral home: [Signature]

44. Signature of undertaker: [Signature]

45. Signature of cemetery: [Signature]

46. Signature of burial place: [Signature]

47. Signature of informant: [Signature]

48. Signature of physician: [Signature]

49. Signature of funeral home: [Signature]

50. Signature of undertaker: [Signature]

51. Signature of cemetery: [Signature]

52. Signature of burial place: [Signature]

53. Signature of informant: [Signature]

54. Signature of physician: [Signature]

55. Signature of funeral home: [Signature]

56. Signature of undertaker: [Signature]

57. Signature of cemetery: [Signature]

58. Signature of burial place: [Signature]

59. Signature of informant: [Signature]

60. Signature of physician: [Signature]

61. Signature of funeral home: [Signature]

62. Signature of undertaker: [Signature]

63. Signature of cemetery: [Signature]

64. Signature of burial place: [Signature]

65. Signature of informant: [Signature]

66. Signature of physician: [Signature]

67. Signature of funeral home: [Signature]

68. Signature of undertaker: [Signature]

69. Signature of cemetery: [Signature]

70. Signature of burial place: [Signature]

71. Signature of informant: [Signature]

72. Signature of physician: [Signature]

73. Signature of funeral home: [Signature]

74. Signature of undertaker: [Signature]

75. Signature of cemetery: [Signature]

76. Signature of burial place: [Signature]

77. Signature of informant: [Signature]

78. Signature of physician: [Signature]

79. Signature of funeral home: [Signature]

80. Signature of undertaker: [Signature]

81. Signature of cemetery: [Signature]

82. Signature of burial place: [Signature]

83. Signature of informant: [Signature]

84. Signature of physician: [Signature]

85. Signature of funeral home: [Signature]

86. Signature of undertaker: [Signature]

87. Signature of cemetery: [Signature]

88. Signature of burial place: [Signature]

89. Signature of informant: [Signature]

90. Signature of physician: [Signature]

91. Signature of funeral home: [Signature]

92. Signature of undertaker: [Signature]

93. Signature of cemetery: [Signature]

94. Signature of burial place: [Signature]

95. Signature of informant: [Signature]

96. Signature of physician: [Signature]

97. Signature of funeral home: [Signature]

98. Signature of undertaker: [Signature]

99. Signature of cemetery: [Signature]

100. Signature of burial place: [Signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7102

CERTIFICATE OF DEATH

Reg. Dist. No. **07092**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <u>Martinsburg</u> 85 x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>218 Frederick Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Edmund</u> Middle <u>Harvey</u> Last <u>Unger</u>				4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 3, 1943</u>	
9. AGE (In years last birthday) <u>15</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Mason L. Unger</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Hoffmaster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>758.6</u> DUE TO <u>congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>aortic valvular insufficiency</u> DUE TO (c) <u>Marfan's syndrome</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>15 years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 26</u> , 19 <u>58</u> , to <u>June 28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 28</u> , 19 <u>58</u> , and that death occurred at <u>5:20 P.M.</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Joel H. Feigon, M.D.</u> ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>6/29/58</u> PHYSICIAN'S NAME (Type) <u>Joel H. Feigon, M.D.</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosedale Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Martinsburg, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Brown-Martinsburg, W. Va.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Search</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7102

DECEASED NAME LAST FIRST MIDDLE SEX AGE DATE OF BIRTH PLACE OF BIRTH OCCUPATION MARITAL STATUS COLOR RELIGION EDUCATION SERVICE GRADE BRANCH DATE OF ENTRY DATE OF DISCHARGE PLACE OF DISCHARGE REASON FOR DISCHARGE DATE OF DEATH PLACE OF DEATH CAUSE OF DEATH MANNER OF DEATH TIME OF DEATH SIGNATURE OF DECEASED SIGNATURE OF WITNESSES SIGNATURE OF CLERK SIGNATURE OF MINISTER SIGNATURE OF JUDGE SIGNATURE OF SHERIFF SIGNATURE OF CORONER SIGNATURE OF HEALTH OFFICER SIGNATURE OF VETERINARY OFFICER SIGNATURE OF CHURCH CLERK SIGNATURE OF SCHOOL TEACHER SIGNATURE OF POSTMASTER SIGNATURE OF TOWN CLERK SIGNATURE OF JUSTICE OF THE PEACE SIGNATURE OF SHERIFF SIGNATURE OF CORONER SIGNATURE OF HEALTH OFFICER SIGNATURE OF VETERINARY OFFICER SIGNATURE OF CHURCH CLERK SIGNATURE OF SCHOOL TEACHER SIGNATURE OF POSTMASTER SIGNATURE OF TOWN CLERK SIGNATURE OF JUSTICE OF THE PEACE		COUNTY STATE DATE OF DEATH PLACE OF DEATH CAUSE OF DEATH MANNER OF DEATH TIME OF DEATH SIGNATURE OF DECEASED SIGNATURE OF WITNESSES SIGNATURE OF CLERK SIGNATURE OF MINISTER SIGNATURE OF JUDGE SIGNATURE OF SHERIFF SIGNATURE OF CORONER SIGNATURE OF HEALTH OFFICER SIGNATURE OF VETERINARY OFFICER SIGNATURE OF CHURCH CLERK SIGNATURE OF SCHOOL TEACHER SIGNATURE OF POSTMASTER SIGNATURE OF TOWN CLERK SIGNATURE OF JUSTICE OF THE PEACE
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Howe & Brown - Baltimore, Md.

6957

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 7 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oakhaven Rest Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle W. Last VANZANT		4. DATE OF DEATH Month June Day 22 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1888
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 10 Days 25	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Ice Manu.		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (State or foreign country) Ontario, Canada		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Uriah Van Zant		14. MOTHER'S MAIDEN NAME Rachel Hamilton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Calvin Vane-son-in-law - Same Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis (c) Hypertension			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 9 a.m. 19 p.m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 19 58 , to June 22 , 19 58 , that I last saw the deceased alive on June 22 , 19 58 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Lawrence A. Rapee M.D. 1150 Conn. Ave. NW			
PHYSICIAN'S NAME (Type) LAWRENCE A. RAPEE Washington, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		22b. DATE THEREOF 6/23/1958	
22c. NAME OF CEMETERY OR CREMATORY Oak Grove		22d. LOCATION (City, town, or county) (State) Becker County Minnesota	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.		24a. REC'D BY REGISTRAR DATE JUN 25 '58	
		24b. REGISTRAR'S SIGNATURE Al L. Smith	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1954-55-56

1991-1992

100 101 102

2001

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

#111
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7103 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07094

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>10100 Ashwood Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Sebastian</u> Last <u>Voigt Jr.</u>		4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 19, 1923</u>
9. AGE (In years last birthday) <u>34</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Prof. Bridge Instructor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Chas S. Voigt Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Glover</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>WW 11</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Hosp. Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Concussion</u> <u>823X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fractures of Skull</u> DUE TO (c) <u>Lacerations, Liver & Spleen</u> Auto Accident Immediate PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of auto. that left highway & struck tree</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>3:30</u> a. m. <u>6/21/58</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>highway</u>		20f. (City or town) (County) (State) <u>Kensington Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6/21/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/25/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Cunningham</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 25 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Al. Leach</u>			

CERTIFICATE OF DEATH

Reg. Dist. No.

7104

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C. Md.</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN TB <u>30 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 15</u>			
				d. STREET ADDRESS <u>5415 Connecticut Ave NW</u>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth Marie Waeber</u> ^{First} <u>Waeber</u> ^{Middle} <u>Waeber</u> ^{Last}				4. DATE OF DEATH Month <u>6</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 8 Approx. 72</u> yrs.	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>22</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Months <u>6</u> Days <u>22</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Denmark</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Korscheen John A</u>				14. MOTHER'S MAIDEN NAME <u>Mueller, Bertha</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Korscheen, George F</u> Address <u>Silver Spring Md. 10007 Portland H.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio sclerosis</u> DUE TO (c) <u>—</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>- 12 hr.</u> <u>- 20 yr.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Subarachnoid Hemorrhage acute</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> , 19 <u>—</u> , to <u>date</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>22 June</u> , 19 <u>58</u> , and that death occurred at <u>4:35 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7936 Kensington Rd.</u> DATE SIGNED <u>23 June 58</u>							
ACTUAL SIGNATURE <u>John G. Ball</u>				M.D. <u>Bethesda Md.</u>			
PHYSICIAN'S NAME (Type) <u>John G. Ball</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/26/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u> ADDRESS <u>—</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JUN 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED JOHN J. HARRIS</p>		<p>2. SEX MALE</p>	
<p>3. AGE 68</p>		<p>4. DATE OF BIRTH JAN 15 1881</p>	
<p>5. PLACE OF BIRTH BALTIMORE, MD.</p>		<p>6. OCCUPATION RETIRED</p>	
<p>7. MARITAL STATUS MARRIED</p>		<p>8. DATE OF MARRIAGE JUN 15 1905</p>	
<p>9. NAME OF SPOUSE MARY J. HARRIS</p>		<p>10. DATE OF DEATH DEC 15 1948</p>	
<p>11. PLACE OF DEATH BALTIMORE, MD.</p>		<p>12. CAUSE OF DEATH HEART DISEASE</p>	
<p>13. MEDICAL HISTORY HYPERTENSION, CORONARY ARTERY DISEASE</p>		<p>14. PRESENT ILLNESS HEART FAILURE</p>	
<p>15. PHYSICIAN'S SIGNATURE J. H. HARRIS</p>		<p>16. PLACE OF INTERMENT BALTIMORE, MD.</p>	
<p>17. NAME OF FUNERAL HOME HARRIS FUNERAL HOME</p>		<p>18. NAME OF MINISTER J. H. HARRIS</p>	
<p>19. NAME OF CLERGYMAN J. H. HARRIS</p>		<p>20. NAME OF BURIAL PLACE BALTIMORE, MD.</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7105

CERTIFICATE OF DEATH

Reg. Dist. No.

07096

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 5 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring		d. STREET ADDRESS 8712 Colesville Rd. Apt. 309	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8712 Colesville Rd. Apt. 309		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle Cosworth Last Walker		4. DATE OF DEATH Month June Day 13 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1878
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Naval Gun Factory	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard A. Walker		14. MOTHER'S MAIDEN NAME SOPHIA ALLEN SOPHIA ALLEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-28-3726	
17. INFORMANT Richard A. Walker, 10.217 Southmoor Dr.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma to rib + spine 177X DUE TO Regrowth of carcinoma of prostate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1 year (c) 6 mo PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SILVER SPRING, MD 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 15 , 19 53 , to June 13 , 19 58 , that I last saw the deceased alive on June 12 , 19 58 , and that death occurred at 12:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) D.B. Washington M.D. 6234 2nd Ave Wash DC DATE SIGNED 6/13/58 ACTUAL SIGNATURE D.B. Washington M.D. PHYSICIAN'S NAME (Type) D.B. Washington MD 6234 2nd Ave Wash DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/16/58	
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wanner & Humphrey		24a. REC'D BY REGISTRAR DATE JUN 16 '58	
ADDRESS Silver Spring, Md.		24b. REGISTRAR'S SIGNATURE W. H. Beach	

CERTIFICATE OF DEATH

I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the person named herein. Physician or Surgeon _____ Date _____		I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the person named herein. Medical Examiner _____ Date _____	
Name of Deceased _____ Sex _____ Age _____ Date of Birth _____		Date of Death _____ Time of Death _____ Place of Death _____	
Cause of Death _____ (To be filled in by physician or surgeon)		Cause of Death _____ (To be filled in by medical examiner)	
Immediate Cause of Death _____ (To be filled in by physician or surgeon)		Immediate Cause of Death _____ (To be filled in by medical examiner)	
Underlying Cause of Death _____ (To be filled in by physician or surgeon)		Underlying Cause of Death _____ (To be filled in by medical examiner)	
Contributing Cause of Death _____ (To be filled in by physician or surgeon)		Contributing Cause of Death _____ (To be filled in by medical examiner)	
Manner of Death _____ (To be filled in by physician or surgeon)		Manner of Death _____ (To be filled in by medical examiner)	
Place of Death _____ (To be filled in by physician or surgeon)		Place of Death _____ (To be filled in by medical examiner)	
Signature of Physician or Surgeon _____ Date _____		Signature of Medical Examiner _____ Date _____	

6958

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7317 Takoma Avenue				d. STREET ADDRESS 7317 Takoma Avenue			
3. NAME OF DECEASED (Type or print) First Frederick Middle R. Last Waterholter				4. DATE OF DEATH Month June Day 3 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1882	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Frederick Waterholter			
14. MOTHER'S MAIDEN NAME Kate Miller				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 578-03-1224				17. INFORMANT Mrs. Melvina E. Waterholter, 7317 Takoma Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) senile arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 months 8-10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Rectum						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 29 Sept , 1953, to 3 June , 1958, that I last saw the deceased alive on 29 May , 1958, and that death occurred at 4:40 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7112 Willow Ave Takoma Park, Md. DATE SIGNED 3 June 1958							
ACTUAL SIGNATURE H. B. Queen M.D.				PHYSICIAN'S NAME (Type) H. B. Queen			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/6/58		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner S. Humphrey				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE JUN 9 '58	
24b. REGISTRAR'S SIGNATURE W. S. Humphrey							

6959

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2004 Harover St.</u> d. STREET ADDRESS <u>Dr Iver Spring Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Weakley, Irene Mamie</u> 4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1958</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 28, 1901</u> 9. AGE (In years last birthday) <u>56</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>hswf</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Stanley Virginia</u> 11. BIRTHPLACE (State or foreign country) <u>U.S.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>William Thomas</u> 14. MOTHER'S MAIDEN NAME <u>Virginia Lamb</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>No</u> 17. INFORMANT <u>Hospital Records & husband of Deceased</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial myocardial infarction</u> (c) <u>Coronary arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>less than 1 hour</u> <u>3 to 4 weeks</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 28, 1958</u> to <u>June 6, 1958</u> , that I last saw the deceased alive on <u>June 5, 1958</u> , and that death occurred at <u>10:35 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Aaron H. Traub</u> PHYSICIAN'S NAME (Type) <u>Aaron H. Traub</u>		ADDRESS (Street, city or town, state) <u>8237 Georgia Ave Silver Spring Md.</u> DATE SIGNED <u>June 6, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>6-8-58</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Family Cem.</u> 22d. LOCATION (City, town, or county) (State) <u>Stanley Va.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 9 '58</u> 24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Budley Funeral Home</u>		ADDRESS <u>Stanley Va.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES H. BROWN		45		M		W		JAN 15 1910	
RESIDENCE		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH	
1234 E. BALTIMORE ST.		HOSPITAL		DISEASE		SUICIDE		YES	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SIGNED	
Carpenter		High School		Roman Catholic		Married		J. H. BROWN	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		SIGNED	
JAN 1 1865		BALTIMORE, MD.		JAN 15 1910		HOSPITAL		J. H. BROWN	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNED	
JAN 15 1910		HOSPITAL		DISEASE		SUICIDE		YES	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SIGNED	
Carpenter		High School		Roman Catholic		Married		J. H. BROWN	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		SIGNED	
JAN 1 1865		BALTIMORE, MD.		JAN 15 1910		HOSPITAL		J. H. BROWN	

RECEIVED
JAN 15 1910
BALTIMORE, MD.

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE THAN THAT FOR WHICH IT WAS ISSUED. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE THAN THAT FOR WHICH IT WAS ISSUED.

7106

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN TB <u>5 hours</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> X				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>			
d. STREET ADDRESS <u>7113 46th Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lucile</u> Middle <u>Webb</u> Last <u>Webb</u>				4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 19, 1905</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James D Ervin</u>				14. MOTHER'S MAIDEN NAME <u>Julia K. Weeks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hospital Record</u>	
Address <u>Bethesda Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> DUE TO <u>754.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Myocardial Insufficiency</u> <u>24 hours</u> (c) <u>Patent Ductus Arteriosus</u> <u>Life</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Fibrosis etiology indeterminate (? Mycotic)</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>June 1, 1958</u> to <u>June 2, 1958</u> , that I last saw the deceased alive on <u>June 2, 1958</u> , and that death occurred at <u>1:15 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stewart Clapp</u>				ADDRESS (Street, city or town, state) <u>3921 Ingomar St. Wash 15 D.C.</u>			
DATE SIGNED <u>6-2-58</u>							
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F Gasch's Sons</u>				ADDRESS <u>Hyattsville Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 5 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7188

NAME OF DECEASED MARY ANN BROWN		SEX F		AGE 68	
DATE OF DEATH APR 15 1961		PLACE OF DEATH HOME		COUNTY BALTIMORE	
TIME OF DEATH 10:30 AM		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
PLACE OF BIRTH BALTIMORE, MD		DATE OF BIRTH APR 15 1893		SEX AT BIRTH F	
OCCUPATION HOUSEWIFE		EDUCATION HIGH SCHOOL		RELIGION METHODIST	
MARITAL STATUS MARRIED		DATE OF MARRIAGE 1915		NAME OF SPOUSE JOHN BROWN	
PREVIOUS ILLNESS YES		DATE OF ONSET APR 10 1961		PHYSICIAN'S NAME DR. J. H. SMITH	
HOSPITAL NAME ST. JOSEPH'S		ROOM NUMBER 123		NURSE'S NAME MRS. J. K. LEE	
SIGNATURE OF PHYSICIAN J. H. SMITH		SIGNATURE OF DECEASED MARY ANN BROWN		SIGNATURE OF WITNESS J. K. LEE	
SIGNATURE OF DECEASED MARY ANN BROWN		SIGNATURE OF WITNESS J. K. LEE		SIGNATURE OF WITNESS J. K. LEE	



This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his last illness. It should be filled out as soon as possible after death, and should be filed in the office of the health officer of the city or county in which the death occurred.

The information furnished on this certificate is for the use of the State Department of Health and is not to be used for any other purpose.

The undersigned hereby certifies that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the health officer of the city or county in which the death occurred.

HEALTH OFFICER
 BALTIMORE, MD

7107

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Henrico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 61 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Richmond 83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 5510 Danley Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle Guy Last Wells, Jr.		4. DATE OF DEATH Month June Day 3 Year 19 58					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 4, 1955	9. AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.	IF UNDER 24 HRS. Months 2 Days 2 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Guy Wells, Sr.				14. MOTHER'S MAIDEN NAME Gladys Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Obstruction secondary to edema of larynx and epiglottis. 204.3 DUE TO (b) Dichloromethotrexate toxicity. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Acute lymphocytic leukemia.						INTERVAL BETWEEN ONSET AND DEATH 8 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 3, 1958 , to June 3, 1958 , that I last saw the deceased alive on June 3, 1958 , and that death occurred at 3:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Roger Lester</i>		M.D. ROGER LESTER, M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 6/4/58	
22a. BURIAL, CREMATION, REMOVAL (specify) Burial		22b. DATE THEREOF 6/5/58		22c. NAME OF CEMETERY OR CREMATORY Westhampton Memorial		22d. LOCATION (City, town, or county) (State) Chesterfield County, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE JUN 6 1958		24b. REGISTRAR'S SIGNATURE <i>W. H. Beach</i>	

MEDICAL CERTIFICATION

2

50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Cheslerfield County, Virginia

Intermittent exposure

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G231 7-8-58 et

CERTIFICATE OF DEATH

07101

Reg. Dist. No.

7108

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Co. Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>565 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>19601-Bristol Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Wallace</u> Middle <u>E</u> Last <u>Wentworth</u>				4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1894</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>safety inspection Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Mass.</u>	
13. FATHER'S NAME <u>James H. Wentworth</u>				14. MOTHER'S MAIDEN NAME <u>Miss Grace Keith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>World War</u>				16. SOCIAL SECURITY NO. <u>152-07-1323</u>		17. INFORMANT Address <u>Mrs. Carolyn H. Wentworth (same)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral infarction, left Parietal</u> 442X DUE TO <u>Cerebral Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> (c) <u>Coronary Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Arteriosclerosis, Bronchopneumonia, Cirrhosis of Liver</u>							
20a. AGE IDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>491X</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>August</u> , 1957, to <u>June 22</u> , 1958, that I last saw the deceased alive on <u>June 22</u> , 1958, and that death occurred at <u>7:20 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Seruch T. Kimble</u>				ADDRESS (Street, city or town, state) <u>929 Pershing Drive Silver Spring Md</u>			
DATE SIGNED <u>6-22-58</u>				M.D. <u>929 Pershing Drive Silver Spring Md</u>			
PHYSICIAN'S NAME (Type) <u>SERUCH T. KIMBLE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>6/23/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 24 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Kimble</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2008

NAME OF DECEASED [Handwritten: John Doe]		SEX [Handwritten: Male]		AGE [Handwritten: 45]	
DATE OF BIRTH [Handwritten: 01/15/1963]		PLACE OF BIRTH [Handwritten: Baltimore, MD]		RACE [Handwritten: White]	
OCCUPATION [Handwritten: Teacher]		CAUSE OF DEATH [Handwritten: Heart Disease]		MANNER OF DEATH [Handwritten: Natural]	
DATE OF DEATH [Handwritten: 08/10/2008]		TIME OF DEATH [Handwritten: 10:30 AM]		PLACE OF DEATH [Handwritten: Home]	
SIGNATURE OF DECEASED [Handwritten: John Doe]		SIGNATURE OF WITNESS [Handwritten: Jane Doe]		SIGNATURE OF PHYSICIAN [Handwritten: Dr. Smith]	
SIGNATURE OF CLERK [Handwritten: Mary White]		SIGNATURE OF REGISTRAR [Handwritten: John Black]		SIGNATURE OF JUDGE [Handwritten: Robert Green]	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT.

6966

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1214 Edmonston Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ISAAC</u> Middle <u>H</u> Last <u>WEST</u>				4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/15/1879</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>28</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer-retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Deleware</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>Joseph P. West</u>				14. MOTHER'S MAIDEN NAME <u>Sarah W. Mitchell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Hilda Werner same as 2 daughter</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> 20 yrs. DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>EPILEPSY</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u></u>				20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I attended the deceased from <u>12-22-1952</u> to <u>6-13-1958</u> that I last saw the deceased alive on <u>5-26-1958</u> , and that death occurred at <u>4:00 A.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. G. Hall</u>				DATE SIGNED <u>6-13-58</u>			
PHYSICIAN'S NAME (Type) <u>W. G. Hall</u>				<u>615 W. Montgomery Ave. Rockville Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>		22b. DATE THEREOF <u>6/13/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Red Mens Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bagsboro, Deleware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 16 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. G. Hall</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07103

7109

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>mont</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2907 Weissman</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mattie</u> Middle <u>A</u> Last <u>Whitman</u>		4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 23, 1865</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u>9</u> Min. <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>New York State</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Edward Dearborn</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Georgia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Nell Whitman</u> Address <u>2907 Weissman Silver Spring, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma lung</u> DUE TO <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>pulmonary edema</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/1/58</u> , 19 <u>58</u> , to <u>6/28/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/27/58</u> , 19 <u>58</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Patrick C Jameson</u> M.D.		ADDRESS (Street, city or town, state) <u>12026 Georgia Silver Spring, Md</u>	
DATE SIGNED <u>6/28/58</u>			
PHYSICIAN'S NAME (Type) <u>Patrick C. Jameson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/30/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Company-Washington, D.C.</u> ADDRESS <u></u>		24a. REC'D BY REGISTRAR <u>Alfred</u> 24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	
DATE <u>JUN 30 '58</u>			

CERTIFICATE OF DEATH

MINNESOTA STATE DEPARTMENT OF HEALTH - BUREAU ONE 10

2190

PLACE ON FILE

DECEASED

DECEASED'S NAME

DECEASED'S AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

EDUCATIONAL ATTAINMENT

DECEASED'S OCCUPATION

DECEASED'S MARITAL STATUS

DECEASED'S PRESENT RESIDENCE

DECEASED'S PRESENT ADDRESS

DECEASED'S PRESENT PHONE NUMBER

DECEASED'S PRESENT MAILING ADDRESS